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DRUG AND ALCOHOL ABUSE PREVENTION PROGRAMS

HEARING

BEFORE THE

SUBCOMMITTEE ON MANPOWER AND PERSONNEL

AND THE

SUBCOMMITTEE ON PREPAREDNESS

OF THE

COMMITTEE ON ARMED SERVICES UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

FIRST SESSION

OCTOBER 4, 1983

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DRUG AND ALCOHOL ABUSE PREVENTION PROGRAMS

TUESDAY, OCTOBER 4, 1983

U.S. SENATE,
COMMITTEE ON ARMED SERVICES,
SUBCOMMITTEE ON MANPOWER AND PERSONNEL
AND SUBCOMMITTEE ON PREPAREDNESS,
Washington, D.C.

The subcommittees met, pursuant to notice, at 10:04 a.m., in room SR-232A, Russell Senate Office Building, Senator Gordon J. Humphrey (chairman of the Subcommittee on Preparedness) presiding.

Members present: Senators Humphrey, Jepsen, and Exon.

Staff present: Patrick A. Tucker, counsel; James G. Roche, minority staff director; Paul C. Besozzi, minority counsel; and Mary Kampo, staff assistant.

Also present: Ron Kelly, assistant to Senator Humphrey; Jon Etherton, assistant to Senator Jepsen; and Mark J. Albrecht, assistant to Senator Wilson.

OPENING STATEMENT BY SENATOR GORDON J. HUMPHREY, PRESIDING

Senator HUMPHREY. Good morning. The Subcommittee on Manpower and Personnel and the Subcommittee on Preparedness have joined together this morning to look at the problem of alcohol and drug abuse in the armed services.

Both these subcommittees last year delved into the 1980 report and resolved to have another look at the problem and progress when the new survey was complete. That survey is now in and that is our purpose here this morning to focus on the survey and to determine what are the plans of the various armed services in response to the data brought out by the 1982 survey.

I want to thank Senator Jepsen, chairman of the Subcommittee on Manpower and Personnel, for his cooperation 2 years ago and likewise this year which is a very important undertaking.

Senator JEPSEN. Thank you, Senator Humphrey, for your continued interest in the subject of drug and alcohol abuse in the armed services and the relationship of these problems to the preparedness of our military forces.

On behalf of the members of the Subcommittee on Manpower and Personnel, I would like to welcome our witnesses before the subcommittee this morning and to express our gratitude for your efforts to combat the effects of what could be a very serious problem, drug and alcohol abuse.

I think it is important to note that the purpose of this hearing is not to imply that our armed services are comprised of an extraordinarily large number of drug and alcohol abusers.

Rather, the problems of drug and alcohol abuse in the military are a reflection of problems which exist in our society at large.

However, this hearing does reflect our understanding that the effects of these problems are far more critical in a military setting, and that aggressive efforts are needed to combat drug and alcohol abuse among our military personnel. If these problems should go unchecked, military readiness will be adversely affected.

I think that drug and alcohol abuse denies the military not only the services of those few military members who are involved in such abuse, but it also impacts adversely upon the morale, welfare, and readiness of those personnel living and working with those who are involved in this abuse.

Our military members deserve a workplace, living quarters and recreation areas where they can be free from the problems associated with drug and alcohol abuse.

As chairman of the Subcommittee on Manpower and Personnel, I am especially concerned with how the quality of life of our service people can be improved. In the testimony we are about to receive I will be looking for insights into how we might improve the quality of life for our military personnel and thereby additionally help prevent alcohol and drug abuse.

Finally, I would like to say that I think the armed services have done a good job of detecting, combating, and preventing drug and alcohol abuse.

The most recent worldwide survey of alcohol and nonmedical drug use among military personnel indicates that drug abuse is on a decline and a very dramatic decline, I might add. A 37-percent reduction is a dramatic drop in the 2-year period between these two surveys.

[See Highlights of 1982 Worldwide Survey, app. A, p. 119.]

I congratulate the services for this trend. But at the same time, that same survey indicates an increase in alcohol abuse. Since alcohol use is legal and is considered socially acceptable, it seems that this problem may be given less attention until it rises to the addiction phase or until a drunk driving arrest occurs.

Nevertheless, I hope to hear today that the services are now embarking on programs to detect alcohol abuse in its early stages and that they are just as aggressive in their efforts to detect such abuse in the workplace as they are with drug abuse.

Only when the joint problems of drug and alcohol abuse are controlled can we expect our military forces to be at their most productive and ready state.

I was asked yesterday by a member of the press why I felt there was a 37- or 38-percent decrease. I said I wasn't sure, but this hearing could provide some of those answers. From the outset, I would suspect it was from the efforts and program you have embarked on.

It also reflects the dramatic change in morale that we have seen in our men and women in uniform today. It is quite different from what it was in 1979 and 1980 when the acceleration of the drug abuse was probably at its peak.

So, I thank you, Mr. Chairman, for your continued diligence and work in this area.

I also express my appreciation to Senator Exon, ranking minority member of the Manpower and Personnel Subcommittee, who has been

not only on target but one of the hardest working ranking members anyone could have on a committee.

He, too, I know, shares the interest in the welfare of the uniformed men and women in this country with the same enthusiasm that I do.

Senator Exon, do you have any remarks?

Senator EXON. Thank you very much, Senator Jepsen.

Mr. Chairman, this morning I am tied up with a tremendously important meeting of another committee down the hall. I just want to be here to thank the witnesses and congratulate them for recognizing the problem and doing something about it.

I am looking forward to the report this morning. I am delighted that the services are united on this problem.

I have before me, Mr. Chairman, a book entitled "1982 Worldwide Survey of Alcohol and Nonmedical Drug Use Among Military Personnel" (see app. A, p. 119). I assume that it addresses only our military personnel and not the potential enemy personnel.

I know it is a very serious problem and you head up the major responsibility for correcting this in the services, and are very much tuned to the fact that we can't move too quickly on this.

I wish this worldwide survey included some idea of what the Soviet problem is, especially in the use of vodka. We can argue all we want about the relative strength of the Soviet Union and the United States in a whole series of areas, but I am convinced, although I have never seen any statistical data to back it up, that there is one place where the Soviets clearly excel and that is in the consumption of alcohol in their armed services.

We must not make light of that fact, but must recognize that the readiness and the preparedness of our manpower particularly, which is the backbone of everything, can be adversely affected.

We have a big jump on the Soviets in this area. I want to see us further ahead. I salute you for what you have done thus far.

Thank you very much.

Senator HUMPHREY. Our witnesses this morning are Dr. John H. Johns, Deputy Assistant Secretary of Defense for Health Promotion; Maj. Gen. John H. Mitchell, Director of Human Resources Development Office, Deputy Chief of Staff for Personnel, Department of the Army; Rear Adm. Paul J. Mulloy, U.S. Navy, Director, Human Resource Management Division, Office of the Chief of Naval Operations; Maj. Gen. Robert C. Oaks, Director of Personnel Plans, U.S. Air Force; and Brig. Gen. James M. Mead, U.S. Marine Corps, Director, Manpower Plans and Policy Division.

May we ask that you summarize your statements. Your full statements will be included in the hearing record.

Good morning to all of you and thank you for coming.

STATEMENT OF JOHN H. JOHNS, DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR HEALTH PROMOTION

Mr. JOHNS. Since we testified before this committee last year, as Senator Jepsen has said, we have made significant progress as is demonstrated on this first chart here which shows in the illicit drugs we have on average reduced the use by around a third, a little more than a third.

COMPARISON: 1980 VERSUS 1982 DRUG USE E1 TO E5 DURING PAST 30 DAYS (PERCENTAGE OF POPULATION)

	1980	1982	Change in rate of abuse percent
Drug:			
Any drug	38	25	−34
Any drug other than cannabis	NA	12	NA
Cannabis	37	22	−40
Amphetamines/stimulants	9	6	−33
Cocaine	7	4	−43
LSD/hallucinogens other than PCP	5	3	−40
Barbiturates/sedatives	3	2	−33
Tranquilizers	3	2	−33
Heroin	1	1	0
Opiates other than heroin	2	1	−50
PCP	1	1	0

That is across the board for marihuana as well as the other drugs. We were able to do that basically because of court decisions that were more favorable in recognizing military necessity for good order and discipline. Earlier decisions in the seventies, what I term liberal, took away our power to do that.

Second, we had a breakthrough in detecting cannabis and marihuana being the most common form in Europe.

Third, we worked out an agreement with the Postal Service to allow our overseas commanders to inspect more mail, to interdict contraband. As a result of this, we did make some great progress there.

This survey was taken in the fall of 1982. Other surveys by the services indicate that the figures are even better than this now. We believe that the 1984 survey will continue this trend and we are well on the way of coping with illicit drugs.

We have been far less successful in dealing with the No. 1 drug problem and that is alcohol. As Senator Jepsen stated, the survey showed that there was an increase in the use of alcohol, particularly beer. The other beverages were not up much, but beer was up significantly. There were more people reported being inebriated and impairment was up.

WORK IMPAIRMENT DUE TO DRUG/ALCOHOL ABUSE DURING PAST 12 MO (PERCENTAGE OF E1 to E5 POPULATION) (1982 VERSUS 1980)

	Drug	Alcohol
Type of impairment:		
Lowered performance	(10) 7	(26) 34
Late for work or left early	(6) 4	(16) 19
Did not come to work	(4) 2	(6) 6
High or drunk while working	(19) 12	(15) 15
Total with any impairment	(21) 14	(31) 40

In the next chart we will compare impairment in the illicit drugs and alcohol. You will see compared to 1980 in drugs we were down 50 percent. Impairment by alcohol was up. Across-the-board impairment went up from 31 to 40 percent during the year from alcohol while it went down from 21 to 14 percent for the illicit drugs. This is in spite of extensive educational programs that we have had to try to teach the responsible use of this legal drug.

Studies by Rand and others show that these extensive educational programs have almost no impact, they just do not last. We are fighting

a cultural phenomenon that is very difficult to turn around. We have attacked it very aggressively when there is adverse behavior as a result of alcohol abuse.

We have an extremely tough drunk-driving regulation that requires, among other things, a revocation of driving privileges for 12 months regardless of whether drunk driving occurs and we do it without waiting for the full court process.

The moment a person is arrested for drunk driving his license is revoked. If they are acquitted, we reinstate them, but if they are convicted, it goes for 12 months. A second offense brings 24 months' revocation.

We are taking some other new initiatives. We now are staffing a policy document with the services that proposes three things.

One, that a 0.05 blood alcohol content on duty is per se impairment on duty and subject to court-martial.

Two, the aggressive use of breathalizers to detect people on duty who may have the 0.05 or more.

And third, a very controversial issue of alining the minimum drinking age for the services for each installation in the State in which that installation is located.

We don't know what the service reaction will be, particularly to that third initiative. It sounds very attractive on the face of it, but as I go around talking to commanders, they say that that will be almost impossible to enforce; but when the military gets an order they salute and try to enforce it.

If they are in a State where the State does not enforce the drinking age, it will present great problems. I do not state how we will come out on that proposal, but we are trying to be as tough as we can on all manner of adverse consequences of alcohol.

When you get to the problem of legal drinking, where people are drinking too much, when you find that 15 percent of the junior enlisted personnel say they drink eight or more beers a day 3 days or more per week for the last year, you have problems, whether or not they come to duty impaired or not.

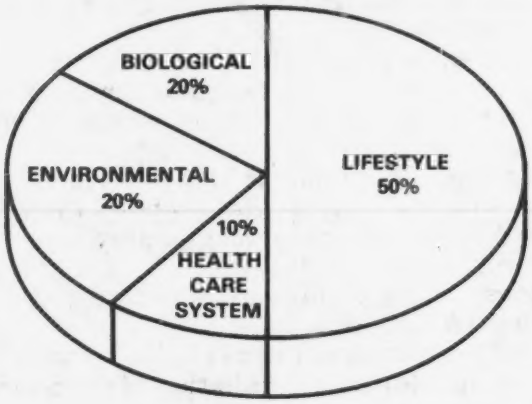
That is a lot of drinking and we want to reduce that. We believe, as we told you last year, and I think this is very important, that the long-term solution to these problems of misbehavior lies in changing the values and norms of our society.

We can go so far in changing the military culture when we are in the midst of a larger society that not only condones alcohol use, but glamourizes it.

The military has its own glamourization policies. Historically we associate a lot of hard drinking with macho military. It will take us a long time to change that. But what we have now and what we call a health promotion effort that the Secretary asked us to do for long term is to develop a way of approaching the whole health issue in a positive sense of emphasizing healthy life styles.

Let me put this in the context of overall health. On these next charts we are going to show you a report by the Center for Disease Control which shows that of the 10 leading causes of death, over 50 percent of them, actually 53 percent, are due to life styles directly.

FACTORS CONTRIBUTING TO MORTALITY



ESTIMATED CONTRIBUTION OF LIFE STYLE TO MORTALITY

	Percentage contribution
Cause of death:	
Heart disease	54
Cancer	37
Cerebral vascular stroke	50
Motor vehicle accidents	69
Suicide	60
Diabetes	34
Average contribution of life style to mortality	50

When you talk about containing health costs, it is not in the health care delivery, new technology of treating diseases that are already there, it is not in biological manipulation. It is going to be largely in changing life styles and that is something that we have never done on a large scale.

The Surgeon General's report in 1979 emphasized this is where we ought to put our emphasis in the eighties. In the military where we have a little more control over the entire institution we want to go about that in a very systematic way, not coercive, but by appealing to grassroots participation, grassroots voluntarism, to get people to put pressure on their peers.

That includes families, retirees, Reserve, National Guard, and civilian employees, a total of about 10½ million people.

Our aim is to create a community which provides the healthy life style environment that Senator Jepsen mentioned so that when young men and women come into the military that will be the norm for their behavior.

Now, this will be a long-term effort. We are going to work at it systematically where we have not done it before. We have done a lot of piecemeal things, but we are going to do it in an integrated fashion and in another few months we will provide you with a strategic plan that lays that out and tells you how we go about it.

I think that we will need the understanding and support of Congress on this because there may be some changes. I am not prepared to say what changes there will be in trying to create this difference, both physical environment and social environment, but we think that there will probably be some.

In summary, the way we are approaching it from the total Department of Defense perspective is to keep pushing hard on the illegal behavior, both on alcohol and illicit drugs and then through positive promotion of healthy life styles try to slowly change the norms and values that cause people to abuse legal substances.

In our presentations here we will go from the Army, Navy, Marines, and Air Force in keeping with their traditional seniority.

[The prepared statement of Mr. Johns follows:]

PREPARED STATEMENT OF JOHN H. JOHNS, DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR HEALTH PROMOTION

The DOD began its extensive drug and alcohol abuse program in the early 1970's and has made significant progress in certain areas in spite of handicaps such as legal restraints and the lack of technology for testing for cannabis. A renewed effort to control alcohol and drug abuse began in 1978.

The 1980 worldwide survey of alcohol and drug abuse in the Armed Forces confirmed that alcohol and marihuana remained the most prevalent drugs of abuse in the military, particularly among young enlisted personnel. Working in close cooperation with other Federal agencies, the Department launched a major offensive to further reduce drug abuse. DOD and NIDA, working with the White House Drug Abuse Policy Office, have refined and improved the techniques for identifying drug abusers through urinalysis. The Department produced a new media campaign for troops overseas that emphasizes healthy lifestyles and has worked closely with the Department of Transportation to conduct a series of workshops to reduce the incidence of drunk driving. These are just a few examples of recent program improvements and interagency cooperation.

The first major initiative to improve the DOD program was the development of the capability to detect marijuana by urinalysis. In the Spring of 1981, chemists at the Armed Forces Institute of Pathology (AFIP) developed a process by which urine samples screened positive for cannabinoid metabolites (by-products of marijuana) could be confirmed using gas liquid chromatography (GLC). This was a major development because it provided field commanders with a biochemical means to detect marijuana use, and it incorporated the process into our laboratory system, which has been analyzing urine specimens for over a decade. The Department now has the capability to detect seven drugs through urinalysis.

The new urinalysis technique was greatly enhanced by favorable court rulings clarifying the evidentiary use of urinalysis results. In 1980, the Court of Military Appeals clarified the law concerning evidentiary use of body fluids by ruling that under specific circumstances results of such tests could support disciplinary action. A more recent decision by the Court of Military Appeals held that urinalysis testing fell within the legal context of both reasonable searches and inspections and did not violate the Fourth Amendment.

Based on the aforementioned developments, in December 1981 the Deputy Secretary of Defense issued a policy memorandum outlining the conditions under which disciplinary actions could be taken on the basis of a positive urinalysis. More detailed policy on urine testing was published in a March 1983 DOD Directive (Enclosure 1).

The DOD policy states that military members may be ordered to provide urine samples for drug urinalysis as part of a military inspection, as the result of a search or seizure action when there exists a probable cause that evidence of drug abuse will be found, and in conjunction with certain medical treatment. In these cases, positive findings of drug abuse may be used to take disciplinary action and to establish the basis for an administrative discharge. The results of such mandatory testing may also be used to refer a servicemember for treatment and rehabilitation.

Mandatory urinalysis may also be ordered to determine a member's competency for duty, to determine whether a member requires counseling or treatment

for drug abuse, in conjunction with a rehabilitation program, as part of a mishap or safety investigation, or any other time when a commander wishes to determine whether drug abuse is a factor in an individual Servicemember's behavior. Under these circumstances, the results of urinalysis may be used to refer the member to a DOD drug abuse treatment and rehabilitation program, but may not be used as evidence against the member in disciplinary action under the Uniform Code of Military Justice (UCMJ) or to support characterization of service in a discharge proceeding. Administrative actions such as removal of a security clearance, however, may be taken.

While the detection and deterrence of illicit drug abuse is of major importance to the Department of Defense, it is of equal importance that non-users not be misindentified as users. To this end the drug testing system has been designed to ensure that any errors that occur are in favor of the individual being tested. Administrative safeguards as well as redundant laboratory procedures have been designed to ensure the integrity of laboratory findings. All samples are handled under strict chain of custody procedures. In addition, each urine specimen submitted for drug urinalysis is subjected to two independent chemical methodologies prior to being reported as positive for the presence of a drug. Urine specimens are screened by either a radioimmunoassay process or an enzyme immunoassay procedure. Those found positive by either of these relatively inexpensive and automated chemical tests are then tested by gas liquid chromatography (GLC). Positive samples are then frozen and retained in the event that a retest is requested.

Another major development in drug urinalysis has been service evaluation of portable urinalysis equipment for on-site testing capability. A one-year field evaluation of this equipment was conducted in 1981–82. The main criterion for the evaluations was the requirement that all positive findings by portable equipment were to be confirmed by GLC in a DOD laboratory. An important factor in the ability of an on-site device to deter drug use is the credibility with which results are perceived to be accurate. There must, therefore, be a high degree of confirmation of field positives by the laboratory. Preliminary results indicated that only about one-half of the portable positives could be subsequently confirmed. Initial suspicions that the portable equipment was inaccurate have proven unfounded. Rather, the device, which uses an enzyme immunoassay process and reacts to the presence of a number of cannabinoid metabolites, is more sensitive than the confirmation procedure. Thus, individuals who have low quantities of cannabis by-products in their urine may indicate positive on the portable device, but negative by laboratory confirmation. Under current DOD policy, such samples must be considered negative. We have been able to improve the confirmation rate of field positives and will continue to work for further improvements.

Two conferences, sponsored jointly by the Department of Defense, the White House Drug Abuse Policy Office, and the National Institute on Drug Abuse, were held in 1982 to discuss the technical aspects of the DOD drug urinalysis program. Conference participants included recognized national authorities in the field or forensic toxicology. The primary purpose of the conferences was to have the DOD drug abuse testing procedures examined by the scientific community and to seek refinements to the state-of-the-art methodology in use in the military laboratories. Both conferences concluded that our program was sound and conferees have continued working with the AFIP and military laboratory officials to improve our ability to confirm the positive results of portable equipment. A third conference is being scheduled for mid October to examine refinements in our standardized testing procedure and to review the data on GLC confirmation.

The Department has continued its emphasis on alcohol and drug abuse education as an integral part of its prevention program. Sequential education is required for all military personnel at key points during career progression. Alcohol and drug abuse education is also required for DOD civilian employees and military dependents. The Department screens, purchases and distributes vast quantities of literature and films which provide up-to-date and accurate information about alcohol and drug abuse. DOD has negotiated an agreement to purchase the rights to reproduce two films entitled, "Epidemic, Kids, Drugs and Alcohol" and "Danger Ahead, Marijuana on the Road." Pamphlets, newsletters and books are purchased at all levels of command in support of this program.

The Department also initiated a new mass media campaign against alcohol and drug abuse. In 1981, 12 radio and 12 television spots were developed and released that emphasized both the danger an abuser poses to the unit and the opportunities for help for those who truly want it. The 1982 campaign featured

17 radio and 17 television spots emphasizing the incompatibility of alcohol and drug abuse with the military lifestyle, with a strong focus on promoting healthy lifestyles. We are presently in the process of developing a series of spots on drunk driving.

DOD continues to offer treatment and rehabilitation to alcohol and drug abusers who truly want and need assistance. The Military Services offer both residential and non-residential care; DOD civilian employees have access to employee assistance type programs and are ordinarily referred to local civilian facilities for care. In August 1981, Department of Defense published an instruction on rehabilitation and referral programs that addresses staff, program and quality assurance for residential, non-residential and referral services and is based on standards developed by the Joint Commission on the Accreditation of Hospitals.

DOD has also taken a more active role in encouraging the development and uniform functioning of Tri-Service treatment facilities for alcohol abuse and alcoholism. The combined resources of the three Armed Services bring an additional dimension of facilitation for both treatment and staff knowledge. The August 1981 DOD instruction on rehabilitation cited above is under revision. The revised version will specify a formal liaison between DOD programs and the Veterans Administration hospitals system to assure continuity of treatment for Servicemembers who fail to respond sufficiently to the military short term rehabilitation program and who are discharged. This revised instruction will also address "choice of treatment" concerns by outlining guidelines to aid in deciding the intensity of treatment for individual cases.

During the latter part of 1982, DOD initiated a collaborative arrangement with NIAAA to assess the effectiveness of treatment for alcohol abuse and alcoholism in the military. To date there is insufficient knowledge to determine the most effective treatment for the diverse military as well as civilian populations who misuse alcohol. This lack of scientific information provided the impetus for mutual inquiry between NIAAA and DOD regarding treatment effectiveness. NIAAA submitted a Statement of Work in early June 1983, thus taking the first formal step of a multiphased research process. A contract was awarded in early August of 1983. Work groups comprised of agreed upon experts by NIAAA and DOD will create five reports:

(1) An Alcohol Treatment Instrument.
(2) An Instrument Assessment Guide.
(3) An Annotated Bibliography.
(4) A Treatment Cost Estimate.
(5) A Research design containing all the necessary data to implement Phase II.

Phase II will involve collecting data on some 5,000 individuals who will have received educational, nonresidential, or residential treatment for alcohol abuse and alcoholism. Phase III and IV will follow-up these patients in an effort to discover what techniques generally seem most effective in treatment and to learn if certain techniques are differently effective for some patients but not for others. To the extent that it is ethically and practically permissible, some randomization to particular types and levels of treatment will occur during these research phases.

In its continuing efforts to monitor alcohol and drug abuse trends in the DOD, a second biennial survey on non-medical drug and alcohol use among military personnel was conducted in 1982. As in the previous surveys, the objectives were to assess the prevalence and consequences of alcohol and drug abuse as well as determine trends that may have occurred since earlier surveys. Over 20,000 servicemembers from the four Services, including both enlisted and officer ranks, participated in the survey. These individuals were randomly selected by name to provide a representative sample. The Research Triangle Institute was awarded the competitive bid contract in January 1982 and completed the worldwide administration for the survey in November.

Results of the survey demonstrate a dramatic decrease (34 percent) between 1980 and 1982 in the number of junior enlisted personnel (E1–E5) reporting current use of illicit drugs. In the 1982 survey, 25 percent of Servicemembers E1 to E5 report having used drugs at least once in the past thirty days versus 38 percent in 1980. Rates in abuse of individual drug classes, including marihuana, reveal similar declines. These results are portrayed in the Table at Enclosure 2.

The findings on heavy alcohol consumption and alcohol-related problems among U.S. military personnel are less favorable. Thirty-eight percent of the 1982 sample

reports having become drunk without planning to at least once in the preceding twelve months versus 20 percent in 1982. More personnel in 1982 (15 percent) also report being inebriated for more than one day at a time in the preceding twelve months than was the case in 1980 (11 percent). Finally, higher percentages of personnel in 1982 reported that alcohol had adversely affected their work performance than was the case in 1980. Forty percent of the junior enlisted and nineteen percent of the senior officers (04–06) now report that alcohol had impaired their performance in the preceding twelve months.. The 1980 figures were 31 and 12 percent for the junior enlisted and senior officers respectively.

The Department also conducted a survey to assess the prevalence and work consequences of drug and alcohol abuse among DOD civilian employees. This survey, which was conducted by mail, involved a worldwide sample of 7,000 randomly selected employees from the Services and Defense Agencies. Another major objective was to determine the feasibility and value of using a survey which was administered by mail. Professional Management Associates of Silver Spring, Maryland was awarded the competitive bid contract. The survey was initiated in the Fall of 1982 and the final report was published in April 1983. The survey found that alcohol and marijuana were the most prevalent drugs used by DOD civilian employees. Six percent report marijuana use in the past year, three percent in the past month. Only one percent were classified as alcohol dependent, although 14 percent reported having 4 or more drinks on an average drinking day. While the response rate approached 85 percent, sensitive items such as number of drinks per day were often skipped by respondents, thus making the value of this survey somewhat limited in value.

In 1982, as part of an interagency agreement with the National Institute on Drug Abuse, DOD conducted a survey of high school seniors in DOD schools overseas. Survey results indicate that the prevalence of illicit drug use among DODDS high school seniors is lower than that of their stateside counterparts but that the prevalence of alcohol and cigarette use is somewhat higher among DODDS seniors (Enclosure 3). During August and September of this year, DODDS and the Air Force co-sponsored family violence and drug and alcohol abuse workshops in four overseas locations. These workshops were attended by military and civilian members of various communities. School nurses, health coordinators, counselors, Air Force Social Actions Officers, mental health specialists and family advocacy officers were represented. The primary objective of this project was to train DODDS personnel to recognize drug and alcohol abuse problems and to establish a referral network between the schools and military communities. We would like to expand this effort next year to include the other Services, school administrators and members of the PTSA's.

Two related efforts are underway to improve management of DOD substance abuse programs. The first of these is directed toward standardizing seven quarterly reports of activities in prevention and rehabilitation. The second effort involves computerizing this data in a relational management information system. Such automation of this data base will permit easy access of relevant indicators to program managers and will permit more efficient production of summary reports. The revised DOD Instruction on reports (Enclosure 4) was signed in August 1983 with the first automated reports expected in early CY84.

Alcohol abuse remains the most serious drug problem and will probably be the most resistant to our efforts. Since it is a legal drug when used in many circumstances, the Department is limited to punitive action only when its use is in violation of law or regulations. The Secretary of Defense began a drive against drunk driving in December 1982, as part of the National Drunk and Drugged Driving Week. A detailed, tough regulation on drunk driving was issued this past August (Enclosure 5). The directive requires alcohol and drug abuse awareness education that focuses on intoxicated driving for law enforcement and safety personnel, club managers, bartenders and waitresses. Individuals charged with intoxicated driving must be screened for chemical dependency within seven working days. Persons guilty of intoxicated driving will lose their base driving privileges for one year for the first offense and for 2 years for the second offense within a 5-year period. The directive also calls for DOD components to establish procedures for notifying the State driver's licensing agency following an intoxicated driving offense and requires an annual report to the Secretary of Defense on the impact of intoxicated driving on the Department.

Three additional measures to reduce alcohol abuse are in the coordination process. These involve establishing a 0.05 BAC while on duty as being impaired for duty, the aggressive use of breathalyzers and the alignment of the legal minimum drinking age on a military installation with that of the state in which the installation is located.

The DOD has also signed an interagency agreement with Department of Transportation, National Highway Traffic Safety Administration (NHTSA) to conduct 12 three-day workshops for base commanders, military police, club managers, and legal and safety personnel. The sessions deal with establishing drunk driver control systems and programs stressing motorcycle safety and vehicle occupant restraint. These workshops are conducted by two instructors from NHTSA and one each from each Service and OSD. This agreement will involve $75,000–$35,000 from NHTSA and $40,000 from DOD. Beyond this NHTSA is committed to provide funds for consultants, travel, and printing. The agreement was signed in mid-December 1982 during the National Drunk and Drugged Driving Awareness Week. Workhops have now been conducted at Fort Belvoir, Norton Air Force Base, the Navy Submarine Base in Bangor, Maine and Fort Rucker. Responses from participants have been positive and the format of the program is being expanded from 3½ to 4 days.

As we testified before this committee last year, we believe the long-term solution to drug and alcohol abuse will require a fundamental change in the values and norms which govern lifestyles in our society. The bulk of drug abuse in the military can be attributed to lifestyles associated with the youth culture of the nation. Alcohol abuse, especially drunk driving, exists to a great extent because society tolerates it; indeed, the use of alcohol by teenagers is glamourized. The Department has undertaken a long-term project to change the values, norms, and attitudes of the military community so that the culture will promote mental and physical well-being, conditions antithetical to drug and alcohol abuse. While this will be a difficult task, it is essential for the long-term solution to the drug and alcohol abuse problem.

Promoting healthy lifestyles to discourage drug and alcohol abuse is one aspect of a comprehensive approach to health promotion designed for DOD-wide implementation in 1984. The objective is to establish an integrated, chain-of-command emphasis on the interactive effects of lifestyles, work settings and environment on health, well-being and productivity within the DOD community. Populations which will be progressively served through this expanded preventive health concept are active duty servicemembers, civilian employees, reservists, retirees and their families.

This broad health promotion initiative capitalizes on medical research demonstrating that the majority of debilitating and life-threatening diseases can be prevented by improvements in individual lifestyle and environment. As reported by the Center for Disease Control in 1978, 50 percent of the 10 leading causes of death can be attributed to lifestyle. Research further indicates that changes must be simultaneously initiated at several levels to be successful—individual, family, work-group, organization, and community.

Currently the Services pursue some components of health promotion in varying degrees, such as physical fitness and weight control. Often projects are implemented in a piecemeal, ad hoc manner without an opportunity to flourish and be sustained over the long term in a supportive institutional climate. Usually health promotion remains the domain of a few health professionals and community volunteers without adequate supporting links to the chain-of-command. By increasing awareness of the elements which constitute successful health promotion and focusing its direction, support and encouragement through the chain-of-command, DOD expects to achieve increased readiness, productivity and lower medical costs.

The measures needed to promote health transcend those actions directly associated with health. Evidence shows that availability of material resources, networks of social support, reasonable level of ability to cope with ordinary challenges, personal sense of commitment to an ideology or social group, and reasonably stable living conditions are critical. Therefore, a comprehensive effort must include actions to influence the entire DOD environment-social psychological and physical. Our goal must be an integrated community that provides a sense of belonging and support. Decisions in DOD, OMB and Congress must consider these factors.

In the final analysis, drug and alcohol abuse is a reflection of the values and lifestyles of our society. As long as these behaviors are embedded in routine habits and social patterns, isolated efforts to change individual behavior will be difficult. Unless desired behaviors are integrated into the culture of the community, the Department, and the Nation, will have limited success. We believe that our systematic, long-term effort to promote healthy lifestyles and to strengthen our military community as one with values and norms which support such lifestyles offers the best hope for the elimination of alcohol and drug abuse as a major health problem in the Armed Forces.

March 16, 1983
NUMBER 1010.1

ASD(HA)

Department of Defense Directive

SUBJECT: Drug Abuse Testing Program

REFERENCES: (a) DoD Instruction 1010.1, "Department of Defense Drug Abuse Testing Program," April 4, 1974 (hereby canceled)
(b) DoD Directive 1010.4, "Alcohol and Drug Abuse by DoD Personnel," August 25, 1980
(c) through (ee) see enclosure 1

A. PURPOSE

1. This Directive replaces reference (a) and, consistent with reference (b), establishes policy for drug abuse urinalysis programs for military personnel; provides guidelines for the use of urinalysis results; outlines testing methodologies, laboratory operation, and quality control; establishes the DoD Biochemical Testing Advisory Committee; assigns responsibilities, and prescribes procedures.

2. This Directive cancels references (c) through (z).

B. APPLICABILITY

This Directive applies to the Office of the Secretary of Defense and the Military Departments. The term "Military Services," as used herein, refers to the Army, Navy, Air Force, and Marine Corps.

C. POLICY

It is DoD policy to use the drug abuse testing program to:

1. Preserve the health of members of the Military Services by identifying drug abusers in order to provide appropriate counseling, rehabilitation, or other medical treatment.

2. Permit commanders to assess the security, military fitness, and good order and discipline of their commands, and to take appropriate action based upon such an assessment.

D. RESPONSIBILITIES

1. The Secretaries of the Military Departments shall:

a. Operate or contract for the operation of drug testing laboratories with enough capacity to meet their drug testing requirements.

b. Arrange for interservice regional use of testing facilities to the maximum extent feasible.

2. The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) shall oversee testing methodology and quality control of the drug abuse screening laboratories.

3. The Secretary of the Army shall coordinate the quality control functions of each laboratory, through the Armed Forces Institute of Pathology (AFIP).

E. PROCEDURES

1. Guidelines for Use of Urinalysis

a. Mandatory urinalysis testing for controlled substances may be conducted in the following circumstances:

(1) Inspection. During inspections performed under Military Rule of Evidence 313 (reference (bb)).

(2) Search or Seizure. During a search or seizure action under Military Rules of Evidence 311-317.

(3) As part of one of the following examinations:

(a) A command-directed examination or referral of a specific servicemember to determine the servicemember's competency for duty and the need for counseling, rehabilitation, or other medical treatment when there is a reasonable suspicion of drug abuse. Such examinations are permissible under Military Rule of Evidence 312(f).

(b) An examination in conjuction with a servicemember's participation in a DoD drug treatment and rehabilitation program. Such examinations are permissible under Military Rules of Evidence 312(f) and 313.

(c) An examination authorized by a rule of the Department of Defense or a Military Department regarding a mishap or safety investigation undertaken for the purpose of accident analysis and the development of countermeasures. Such examinations are permissible under Military Rules of Evidence 312(f) and 313.

(4) Any other examination ordered by medical personnel for a valid medical purpose under Military Rules of Evidence 312(f) including emergency medical treatment, periodic physical examinations, and such other medical examinations as are necessary for diagnostic or treatment purposes.

b. Although the DoD drug testing program is designed for specific administrative purposes, the use of urinalysis results in disciplinary or administrative proceedings is permitted except as otherwise limited in the Military Rules of Evidence, this Directive, or rules issued by the Department of Defense or the Military Departments.

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2. Limitations on Use of Urinalysis Results

a. Results obtained from urinalysis performed under subparagraph E.1.a.(3), above, may not be used against the servicemember in actions under the UCMJ (reference (aa)) or on the issue of characterization of service in separation proceedings.

b. A servicemember's voluntary submission to a DoD treatment and rehabilitation program, and voluntarily disclosed evidence of prior personal drug use by the member as part of a course of treatment in such a program, may not be used against the member in an action under reference (aa) or on the issue of characterization of service in a separation proceeding.

c. Records of the identity, diagnosis, prognosis, or treatment of any rehabilitee that are maintained in connection with the performance of any drug abuse rehabilitation program conducted, regulated, or directly or indirectly assisted by any department or agency of the United States may not be introduced against the rehabilitee in a court-martial except as authorized by a court order issued under the standards set forth in 21 U.S.C. 1175(b)(2)(c) (reference (ee)).

d. The limitations in paragraphs 2.a., b., and c., above, do not apply to:

(1) The introduction of evidence for impeachment or rebuttal purposes in any proceeding in which the evidence of drug abuse (or lack thereof) has been first introduced by the servicemember.

(2) Disciplinary or other action based on independently derived evidence, including evidence of continued drug abuse after initial entry into a treatment and rehabilitation program.

3. Collection and Transportation of Urine Specimens. All urinalysis specimens shall be collected and transported under the chain of custody procedures outlined in enclosure 2.

4. Portable Urinalysis Equipment. All positive drug screening results from portable urine testing equipment shall be considered preliminary until confirmed by gas liquid chromatography or gas chromatography/mass spectrometry at a drug testing laboratory or by admission of the servicemember. Preliminary results that are not confirmed as positive may not be used against a servicemember in disciplinary proceedings or as the basis for administrative separation.

5. Laboratory Procedures. The policy pertaining to the operation of drug urinalysis laboratories is described in enclosure 3.

6. Laboratory Certification. Certification of an individual laboratory is dependent on maintaining AFIP quality control standards and on submitting required reports in a timely manner. Failure to meet either of these two requirements may result in decertification.

7. Contract Laboratories. Contractual arrangements with civilian drug testing laboratories are permitted, providing such laboratories become incorporated into the AFIP quality control program, meet and maintain DoD certification and quality control standards, and conform to the chain of custody requirements for all specimens analyzed (see enclosure 2).

Mar 16, 83
1010.1

F. DoD BIOCHEMICAL TESTING ADVISORY COMMITTEE

1. Organization and Management

a. The DoD Biochemical Testing Advisory Committee is hereby established to advise the Deputy Assistant Secretary of Defense (Drug and Alcohol Abuse Prevention) (DASD(DAAP)) on technical matters pertaining to the DoD biochemical testing program for drug and alcohol abuse.

b. The Committee shall be composed of one member each from the Army, Navy, and Air Force, preferably from the staffs of the Surgeons General, one member from the DoD Office of Drug and Alcohol Abuse Prevention who shall serve as committee chairman, one member from the AFIP, and any other members as designated by the DASD(DAAP).

2. Functions. The Committee shall make recommendations to the DASD(DAAP) on the following:

a. Standardized laboratory methodology for screening and confirmation testing.

b. New technology for the identification of drug and alcohol abusers.

c. Appropriate quality control procedures for drug testing laboratories.

d. Procedures and standards for the certification, decertification, and recertification of laboratories.

e. Applied research projects to improve the effectiveness of the DoD drug and alcohol abuse biochemical testing program.

G. EFFECTIVE DATE AND IMPLEMENTATION

1. This Directive is effective immediately. Forward two copies of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days.

Paul Thayer
PAUL THAYER
Deputy Secretary of Defense

Enclosures - 3
1. References
2. Chain of Custody Procedures for Collecting, Handling, and Testing Urine Samples for Drug Detection Urinalysis
3. Laboratory Procedures

REFERENCES, continued

(c) Assistant Secretary of Defense (Health and Environment)(ASD(H&E)) Memorandum, "Forensic Use of DoD Drug Testing Laboratories," February 5, 1973 (hereby canceled)
(d) ASD(H&E) Memorandum, "Statistical Comparability of Drug Testing Laboratory Results," May 10, 1974 (hereby canceled)
(e) Deputy Assistant Secretary of Defense (Drug and Alcohol Abuse) Memorandum, "Drug Testing Laboratories Cutoff Levels," May 30, 1974 (hereby canceled)
(f) ASD(H&E) Memorandum, "Authority to Direct Urinalysis for Drug Abuse Detection," November 18, 1975 (hereby canceled)
(g) Assistant Secretary of Defense (Health Affairs)(ASD(HA)) Memorandum, "Forensic Use of the Department of Defense Drug Testing Laboratories," June 16, 1976 (hereby canceled)
(h) ASD(HA) Memorandum, "Department of Defense Drug Abuse Testing Program," August 30, 1976 (hereby canceled)
(i) ASD(HA) Memorandum, "Radioimmunoassay Cutoff Levels for Urinalyses Conducted in Drug Testing Laboratories," May 2, 1977 (hereby canceled)
(j) ASD(HA) Memorandum, "Radioimmunoassay Cutoff Levels for Urinalyses Conducted in Drug Testing Laboratories," June 14, 1978 (hereby canceled)
(k) ASD(HA) Memorandum, "Discontinuance of Urine Test Screening of Officer Accessions," December 20, 1978 (one version to Army and Navy, and one version to Air Force) (both hereby canceled)
(l) ASD(HA) Memorandum, "Drug Detection Urinalysis Laboratory Points of Contact," January 10, 1979 (hereby canceled)
(m) ASD(HA) Memorandum, "Radioimmunoassay Cutoff levels for Urinalyses Conducted in Drug Testing Laboratories," September 21, 1979 (hereby canceled)
(n) Deputy Secretary of Defense (DEPSECDEF) Memorandum, "DoD Policy Regarding Cannabis Use," November 5, 1979 (hereby canceled)
(o) ASD(HA) Memorandum, "Confirmation of Drug Abuse," December 28, 1979 (hereby canceled)
(p) ASD(HA) Memorandum, "Urinalysis for Drug Abuse Detection," January 7, 1980 (hereby canceled)
(q) ASD(HA) Memorandum, "Exempting Commissioned Officers Assigned to Alcohol and Drug Abuse Treatment Staffs from Mandatory Urine Testing," April 1, 1980 (hereby canceled)
(r) ASD(HA) Memorandum, "Cocaine Abuse," April 21, 1980 (hereby canceled)
(s) ASD(HA) Memorandum, "Entry on Active Duty (EAD) Urinalysis," July 11, 1980 (hereby canceled)
(t) ASD(HA) Memorandum, "Entry on Active Duty (EAD) Urinalysis," July 31, 1980 (hereby canceled)
(u) ASD(HA) Memorandum, "Drug Testing for Cocaine," April 9, 1981 (hereby canceled)
(v) ASD(HA) Memorandum, "Urine Testing for Cannabis in the Department of Defense," August 28, 1981 (hereby canceled)
(w) DEPSECDEF Memorandum, "Alcohol and Drug Abuse," December 28, 1981 (hereby canceled)
(x) ASD(HA) Memorandum, "Chain of Custody Procedures," April 19, 1982 (hereby canceled)
(y) DEPSECDEF Memorandum, "Drug Testing in the Department of Defense," August 6, 1982 (hereby canceled)
(z) ASD(HA) Memorandum, "Department of Defense Laboratory Committee for Drug Abuse Testing," August 11, 1982 (hereby canceled)

(aa) Title 10, United States Code, Chapter 47 (Uniform Code of Military Justice)
(bb) Manual for Courts-Martial, Military Rules of Evidence, 311-317
(cc) DoD Directive 1332.14, "Enlisted Administrative Separations," January 28, 1982
(dd) DoD Directive 1332.30, "Separation of Regular Commissioned Officers for Cause," October 15, 1981
(ee) Title 21, United States Code, 1175(b)(2)(c)

CHAIN OF CUSTODY PROCEDURES
FOR
COLLECTING, HANDLING, AND TESTING URINE SAMPLES
FOR
DRUG DETECTION URINALYSIS

A. GENERAL

1. Chain of custody procedures are designed to ensure accuracy in referral of servicemembers for counseling and rehabilitation programs, and to ensure that commanders are provided with an accurate assessment of the military fitness of the command. Such procedures also ensure that any incidental use of urinalysis results in other proceedings will be based upon reliable procedures.

2. The individual directing that a urine test be conducted shall identify, as appropriate, the servicemember, work group, unit (or part thereof) to be tested. A responsible individual, such as the alcohol and drug coordinator or the base or unit urine test program monitor, shall be assigned to coordinate urine collection.

B. PREPARATION OF SPECIMEN BOTTLES

1. The urinalysis program coordinator shall:

a. Ensure that appropriate specimen bottles are used and that each is properly prepared.

b. Ensure that each bottle has a gummed label affixed to it on which the coordinator shall record the date, specimen number, and any additional identifying information required by each Military Service.

c. Maintain a ledger documenting the above identifying information and the servicemember's name and social security number, and the name of the designated observer (subsection C.2., below).

2. The servicemember submitting the specimen shall verify all identifying information by signing the ledger and initialing the label on the bottle.

C. COLLECTION OF SPECIMENS

1. The urinalysis program coordinator shall:

a. Ensure that each specimen is collected under the direct observation of a designated individual of the same sex as the servicemember providing the specimen.

b. Ensure that a minimum volume of 60 milliliters is collected.

c. Initial the label on the bottle as verification of receipt and shall annotate appropriate chain of custody documents.

2. The observer shall ensure that the specimen is not contaminated or altered in any way.

D. TRANSPORTATION OF SPECIMENS

1. The urinalysis coordinator shall:

a. Ensure that specimens are shipped in appropriate specimen boxes or padded mailers.

b. Ensure that each container is securely sealed.

c. Sign and date each container across the tape sealing the top and bottom.

d. Ensure that chain of custody documentation is attached to each sealed container.

e. Ensure that an outer mailing wrapper is placed around each sealed container.

2. Containers shall be shipped expeditiously by registered mail, Military Airlift Command transportation system, commercial air freight or air express. Specimens also may be handcarried.

E. LABORATORY HANDLING

1. Each Military Department shall ensure that each of its drug testing laboratories establishes internal laboratory chain of custody procedures.

2. Testing results shall be annotated on appropriate forms. Completed laboratory results forms, chain of custody documents, intralaboratory chain of custody documents, and the gas chromatograph tracings of all reported positive specimens, or copies of the above, shall remain on file in the drug testing laboratory for a minimum of 1 year.

3. Military Service regulations may provide for the prompt forwarding of the completed original (or certified copy of) chain of custody and laboratory results documents, intralaboratory chain of custody documents, or alternatively, retention of this documentation by the drug testing laboratory for a period of at least 1 year, to be promptly forwarded to the originating command or other proper authority, upon request, when required for administrative or disciplinary action.

LABORATORY PROCEDURES

A. GENERAL

1. Standardized drug testing methodologies, procedures, and criteria shall be maintained in all drug testing laboratories operated by or for the Department of Defense.

2. In all cases two independent methodologies are required to confirm the presence of a drug, or its metabolite, in a urine specimen before a report of a positive finding is released to the originating unit.

B. DRUGS TESTED

The determination of which drugs shall be tested by each laboratory shall be made on the basis of drug use patterns. Since this will change periodically, requirements shall be established by ASD(HA) memoranda.

C. CHAIN OF CUSTODY

All urine specimens shall be processed under chain of custody procedures. Each laboratory shall establish specific internal laboratory procedures which shall be subject to ASD(HA) approval as specified in enclosure 2.

D. SCREENING

All urine specimens shall be screened by either a radioimmunoassay or an enzyme immunoassay process. Screening sensitivity levels shall be established by ASD(HA) memoranda.

E. CONFIRMATION

All specimens screened positive by an immunoassay process shall be tested by gas liquid chromatography for confirmation. Either flame ionization, nitrogen phosphate, or mass spectrometer detection systems may be used.

F. REPORTING

Confirmed positive results shall be reported either by message or telephone to the originating unit within 5 working days of receipt of a batch of specimens. This report shall state that the balance of the specimens in the batch were negative. Service regulations may require written followup reporting.

G. DISPOSITION OF SPECIMENS

1. Urine specimens which test negative shall be discarded.

2. Urine specimens that are not consumed in the testing proces and that are confirmed positive shall be retained in a frozen state for a period of 60 days following the report required in section F., above. If the urinalysis result is used in a court-martial or administrative proceeding, the unit shall request that the specimen be retained at least until the trial or hearing is

complete. This does not require retention during review proceedings, but such additional retention requirements may be established by the the Military Departments.

H. QUALITY CONTROL

1. At intervals set by the Secretary of the Army, acting as executive agent for quality control, the Director, AFIP, shall provide laboratory quality control reports for the use of the Military Departments and the Office of the DASD(DAAP) in determining laboratory proficiency.

2. Each of the other Military Departments shall support, as necessary, the Army's function of quality control agent for the Military Departments' testing programs.

Percentage of
SUBSTANCE ABUSERS AMONG E-1 to E-5 MILITARY
PERSONNEL DURING THE PAST 30 DAYS
1982[a] vs 1980[b]

	Army		Navy		Marine Corps		Air Force		Total DoD	
	1982	1980	1982	1980	1982	1980	1982	1980	1982	1980
Any Drug	34	(41)	21	(48)	25	(48)	18	(21)	25	(38)
Any Drug Other Than Marijuana	14	(NA)	12	(NA)	14	(NA)	7	(NA)	12	(NA)
Marijuana/ Hashish	31	(40)	17	(47)	21	(47)	15	(20)	22	(37)
Amphetamines/ Stimulants	7	(8)	7	(15)	7	(10)	3	(4)	6	(9)
Cocaine	5	(6)	4	(11)	4	(10)	2	(2)	4	(7)
LSD/Hallucinogens	4	(3)	3	(7)	5	(10)	1	(2)	3	(5)
Barbiturates/ Sedatives	2	(4)	2	(5)	1	(4)	1	(1)	2	(3)
Tranquilizers	2	(3)	2	(4)	2	(3)	1	(1)	2	(3)
Heroin	1	(2)	1	(1)	1	(0)	0	(0)	1	(1)
Opiates Other than Heroin	2	(2)	1	(2)	1	(2)	0	(1)	1	(2)
PCP	1	(2)	1	(2)	1	(4)	0	(0)	1	(1)

Source:

a/ 1982 Worldwide Survey of Military Drug and Alcohol Abuse
b/ 1980 Worldwide Survey of Military Drug and Alcohol Abuse

Enclosure 2

PREVALENCE OF TYPES OF DRUGS, DODDS AND STATESIDE CLASS OF 1982

(APPROX. N STATESIDE = 17,700)
(APPROX. N DODDS = 3,400)

	EVER USED		PAST MONTH	
	STATESIDE	DODDS	STATESIDE	DODDS
MARIJUANA/HASHISH	68.7	57.6	28.5	27.0
INHALANTS	18.0	22.2	2.5	2.8
AMYL/BUTYL NITRITES	9.8	7.8	1.1	1.6
HALLUCINOGENS	15.0	13.9	4.3	2.7
LSD	9.6	10.1	2.4	2.0
PCP	6.0	5.3	1.0	0.1
COCAINE	16.0	12.8	5.0	2.2
HEROIN	1.2	2.4	0.2	0.3
OTHER OPIATES	9.6	13.8	1.8	3.0
←STIMULANTS	27.9	24.1	10.7	6.6
SEDATIVES	15.2	17.0	3.4	3.0
BARBITURATES	10.3	13.8	2.0	2.2
METHAQUALONE	10.7	8.8	2.4	1.1
TRANQUILIZERS	14.0	18.1	2.4	3.0
ALCOHOL	92.8	96.4	69.7	78.5
CIGARETTES	70.1	75.9	30.0	36.1

Enclosure 3

August 4, 1983
NUMBER 1010.3

Department of Defense Instruction

ASD(HA)

SUBJECT: Drug and Alcohol Abuse Reports

References: (a) DoD Instruction 1010.3, "Drug and Alcohol Abuse Reports," May 22, 1974 (hereby canceled)
(b) DoD Instruction 7730.51, "Semi-Annual Report of Disciplinary Actions Taken for Drug Abuse Offenses," January 7, 1969 (hereby canceled)
(c) DoD Directive 1010.4, "Alcohol and Drug Abuse by DoD Personnel," August 25, 1980
(d) DoD Instruction 6055.7, "Mishap Investigation, Reporting and Recordkeeping," December 16, 1981
(e) through (k), see enclosure 1

A. REISSUANCE AND PURPOSE

1. This Instruction reissues reference (a), incorporates reference (b), assigns responsibilities, and prescribes added reporting requirements associated with drug and alcohol abuse in the Department of Defense.

2. This Instruction cancels Report Control Symbols DD-H&E(Q)1170, DD-H&E(Q)1328, DD-H&E(Q)1329, DD-H&E(M)1194, DD-H&E(Q)1330, and DD-HA(Q)1588.

B. APPLICABILITY AND SCOPE

This Instruction applies to the Office of the Secretary of Defense, the Military Departments, and the Defense Agencies (hereafter referred to as "DoD Components"). The term "Military Services," as used herein, refers to the Army, Navy, Air Force, and Marine Corps.

C. DEFINITIONS

Terms used in this Instruction are defined in reference (c).

D. POLICY

It is the policy of the Department of Defense to identify drug and alcohol abusers early and rehabilitate those who have a proven potential for further useful service. The Department of Defense has devised a system of information gathering that shall provide:

1. The scope of the drug and alcohol abuse problem.

2. An evaluation of the effectiveness of the Military Services' educational, enforcement, medical treatment, and rehabilitation programs.

3. Data to base replies to public, congressional, and other governmental agency inquiries, and to support budget requests for drug and alcohol abuse funds.

4. Data to effect changes that will reduce or eliminate the drug and alcohol abuse problem.

E. RESPONSIBILITIES

1. Heads of DoD Components shall submit the reports required in section F. to the Deputy Assistant Secretary of Defense (Drug and Alcohol Abuse Prevention), Office of the Assistant Secretary of Defense (Health Affairs).

2. The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) shall use the data from these reports to meet the requirements of section D.

F. INFORMATION REQUIREMENTS

1. The reporting requirements of this Instruction have been assigned the following Report Control Symbols (RCSs):

a. RCS DD-HA(Q)1169, enclosure 2.
b. RCS DD-HA(Q)1585, enclosure 3.
c. RCS DD-HA(Q)1094, enclosure 4.
d. RCS-DD-HA(Q)1586, enclosure 5.
e. RCS-DD-HA(Q)1587, enclosure 6.
f. RCS DD-HA(Q)933, enclosure 7.
g. RCS DD-HA(Q)1627, enclosure 8.

2. All reports shall be submitted quarterly and are due the 45th day following the end of the quarter. Reports cover the periods ending March 31, June 30, September 30, and December 31. The first set of quarterly reports covers October through December 1983.

3. Mishap data with drug or alcohol involvement is required by DoD Instruction 6055.7 (reference (d)).

4. The Military Services shall submit all reports except enclosure 2, which is submitted only by the Army. The Defense Agencies and the Director, Personnel and Security, Washington Headquarters Services, shall submit only the report at enclosure 8. When applicable, the Military Services shall report military personnel on active duty, reservists on annual training for 72 hours or longer, and National Guardsmen on federal service.

5. With the exception of the report at enclosure 2, reports shall be submitted by four geographic areas: Continental United States (CONUS), Europe, Pacific, and Other, according to the Unified Command Plan. The European area comprises the area of responsibility of the U.S. European Command and the Pacific area that of the U.S. Pacific Command. The reports from all military entrance processing stations (MEPS) (enclosure 2) shall be consolidated into one report.

6. The memorandum transmitting the reports at enclosure 2 through 8 shall contain a narrative, summarizing the trends indicated by the reporting data, and describing problems and accomplishments.

7. If a reporting requirement is satisfied from an automated data file or system, standard data elements published in DoD 5000.12-M (reference (e)) shall be used.

G. EFFECTIVE DATE AND IMPLEMENTATION

This Instruction is effective immediately. Forward two copies of the implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days.

John Beary

John F. Beary III, M.D.
Acting Assistant Secretary of Defense
(Health Affairs)

Enclosures - 8
1. References
2. Format for Medical Rejections at Military Entrance Processing Stations for Drug and Alcohol Abuse (RCS DD-HA(Q)1169) and Instructions
3. Format for Report of Service Members Identified as Drug or Alcohol Abusers (RCS DD-HA(Q)1585) and Instructions
4. Format for Urinalysis Testing for Drug Abuse (RCS DD-HA(Q)1094) and Instructions
5. Format for Report of Military Law Enforcement Activity (RCS DD-HA(Q)1586) and Instructions
6. Format for Report of Clients in Treatment or Rehabilitation for Drug or Alcohol Abuse (RCS DD-HA(Q)1587) and Instructions
7. Format for Legal or Administrative Disposition of Drug Abuse Offenders (RCS DD-HA(Q)933) and Instructions
8. Format for Report of Civilian Employee Alcohol and Drug Abuse (RCS DD-HA(Q)1627) and Instructions

REFERENCES, continued

(e) DoD 5000.12-M, "DoD Manual for Standard Data Elements," December 1982, authorized by DoD Instruction 5000.12, "Data Elements and Data Codes Standardization Procedures," April 27, 1965
(f) Title 21, United States Code, Section 801 (Public Law 91-513, "Comprehensive Drug Abuse Prevention and Control Act of 1970," October 27, 1970)
(g) Deputy Secretary of Defense Memorandum, "Alcohol and Drug Abuse," December 28, 1981
(h) Title 10, United States Code, Chapter 47, "The Uniform Code of Military Justice"
(i) Manual for Courts-Martial, United States, as amended

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1010.3 (Encl 2)

FORMAT FOR
MEDICAL REJECTIONS AT
MILITARY ENTRANCE PROCESSING STATIONS
FOR DRUG AND ALCOHOL ABUSE REPORT
(RCS DD-HA(Q)1169)

1. Military Service:

2. Report period (from YYMMDD to YYMMDD):

3. Number examined:

4. Number rejected for abuse of:
   (See definitions on reserve side.)

   a. Opiates

   b. Amphetamines:

   c. Barbiturates:

   d. Cannabis:

   e. Other drugs:

   f. Abuse:

   g. Alcohol:

5. Total number rejected for drug or alcohol abuse:

6. Name and title of individual preparing report (Last, First, MI):

   Telephone number (include area code):

   Date submitted (YYMMDD):

INSTRUCTIONS FOR RCS DD-HA(Q)1169

MEDICAL REJECTIONS AT MILITARY ENTRANCE
PROCESSING STATIONS FOR DRUG AND ALCOHOL ABUSE REPORT

1. Military Service: Reports for all Military Services are compiled and submitted by the Army as executive agent for MEPS operations.

2. Report period: Quarterly, as described in subsection F.2., basic Directive.

3. Number examined: Indicate the total number of recruits in the region who completed the physical for entry into the Military Services during the report period.

4. Number rejected: Indicate the number of recruits in the region who were denied entry into the Armed Forces of the United States because of a drug or alcohol dependency problem or because of past drug- or alcohol-related legal problems (such as driving while intoxicated) (see categories 4.a. through 4.g.).

a. Definitions of the drug classes are contained in the regulations promulgated by the Attorney General of the United States under the authority of Pub. L. 91-513 (reference (f)).

b. Polydrug abuse is the abuse of two or more drugs during the same relative time period; the abuse of the drugs simultaneously is not implied. Examples of nonspecific drug classes:

Opiates	-	Opium, morphine, codeine, Demerol, Dilaudid, methadone, heroin.
Barbiturates	-	Amytal, Butisol, phenobarbital, Seconal
Amphetamines	-	Benzedrine, Biphetamine, Dexedrine
Cannabis	-	Marijuana, hashish, hashish oil
Other drugs	-	Inhalants

5. Total number rejected for drug or alcohol abuse: Indicate total of 4.a. through 4.g.

6. Authentication of report: Indicate the name, title, and telephone number of the individual who is preparing the report and is responsible for its accuracy. Also, indicate the date the report is forwarded.

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Aug 4, 83
1010.3 (Encl 3)

FORMAT FOR
REPORT ON SERVICE MEMBERS IDENTIFIED AS DRUG OR ALCOHOL ABUSERS
(RCS DD-HA(Q)1585)

1. Military Service:

2. Reporting period (from YYMMDD to YYMMDD):

3. Geographic area:

4. Definitions, see reverse side.

5. Initial means of identification, see reverse side.

6. Explanation of categories, see reverse side.

Primary drug of abuse	a. Commander or Supervisor	b. Self-referral	c. Urinalysis	d. Medical	e. Law enforcement
Alcohol					
Heroin					
Other opiates					
Methaqualone					
Barbiturates					
Tranquilizers					
Other depressants					
Cocaine					
Amphetamines					
Other stimulants					
LSD					
Phencyclidine					
Other hallucinogens					
Cannabis					
Other					

7. Name and title of individual preparing report (Last, First, MI):

Telephone number (include area code):

Date submitted (YYMMDD):

Aug 4, 83
1010.3 (Encl 3)

INSTRUCTIONS FOR RCS DD-HA(Q)1585

REPORT ON SERVICE MEMBERS IDENTIFIED
AS DRUG OR ALCOHOL ABUSERS

1. Military Service: Identify by name the Military Service submitting the report.

2. Reporting period: Quarterly, as described in subsection F.2., basic Directive.

3. Geographic area: The geographic areas are described in subsection F.5., basic Directive.

4. Definitions of the drug classes are contained in the regulations promulgated by the Attorney General of the United States under the authority of Pub. L. 91-513 (reference (f)). Examples of nonspecific drug classes:

Other opiates	-	Opium, morphine, codeine, Demerol, Dilaudid, methadone
Barbiturates	-	Amytal, Butisol, phenobarbital, Seconal
Tranquilizers	-	Equanil, Librium, Miltown, Serax, Valium
Other depressants	-	Clonopin, Dalmane, Nolundar, Valmid
Amphetamines	-	Benzedrine, Biphetamine, Dexedrine
Other stimulants	-	Barcarate, Didrex, Pre-Sate, Sanorex, Voranil
Cannabis	-	Marijuana, hashish, hashish oil
Other	-	Inhalants

5. Initial means of identification: For the five categories of identification, indicate the total number of members initially identified as having a drug or alcohol abuse problem during the report period by the primary drug of abuse only, that is, the drug which caused the most dysfunction. Only one primary drug is to be reported.

6. Explanation of the five categories of identification:

a. Commander or supervisor identifications are only those authentic referrals that are initiated by the commander or supervisor. These identifications do not include commander or supervisor referrals that are accomplished after the referred member's drug or alcohol problem is brought to the commander's or supervisor's attention by other means, such as, informants, health and welfare inspections, or personnel with a confirmed positive urine sample (submitted upon their demonstration of bizarre or irregular behavior).

b. Self-referral identifications are only those members who are authentic volunteers for treatment and rehabilitation under the exemption policy promulgated by Deputy Secretary of Defense memorandum (reference (g)). Do not include in this category those who are first detected as drug abusers by other means (such as urinalysis testing) and who thereafter agree to drug abuse treatment and rehabilitation.

c. Urinalysis identifications are those confirmed by the commander as authentic drug abusers following notification that the member concerned submitted a urine sample which was found positive for a drug of abuse. This includes random and unit sweeps.

d. Medical identifications are those referred by medical personnel in the exercise of their medical duties.

e. Law enforcement identifications are those brought to the attention of appropriate authorities through military or civilian police or investigative agency activity.

7. Authentication of report: Indicate the name, title, and telephone number of the individual who is preparing the report and is responsible for its accuracy. Also, indicate the date the report is forwarded.

FORMAT FOR
URINALYSIS TESTING FOR DRUG ABUSE REPORT
(RCS DD-HA(Q)1094)

1. Military Service:

2. Reporting period (from YYMMDD to YYMMDD):

3. Geographic area:

4. Occasion for test	NUMBER OF LABORATORY POSITIVES								5. Number of specimens tested
	Cannabis	Cocaine	Opiates	Methaqualone	Amphetamines	Barbiturates	PCP	Polydrug	Other
a. Inspection									
b. Probable cause search or seizure									
c. Command-directed									
d. Medical									
TOTAL									

6. Name and title of individual preparing report (Last, First, MI):

Telephone number (include area code):

Date submitted (YYMMDD):

INSTRUCTIONS FOR RCS DD-HA(Q)1094
URINALYSIS TESTING FOR DRUG ABUSE REPORT

1. Military Service: Identify by name the Military Service submitting the report.

2. Reporting period: Quarterly, as described in subsection F.2., basic Directive.

3. Geographic area: The geographic areas are described in subsection F.5., basic Directive.

4. Occasion for test:

a. Inspection. An inspection under Military Rule of Evidence 313, (reference (h)).

b. Probable Cause Search or Seizure. A search or seizure under Military Rules of Evidence 311-317 (reference (h)).

c. Command-Directed. A command-directed examination or referral of a specified member for a valid medical purpose under Military Rule of Evidence 312(f) (reference (h)) when there is a reasonable suspicion of drug abuse, an examination of a specified member incident to a mishap or safety investigation, or an examination of a specified member in conjunction with a member's participation in a DoD drug treatment and rehabilitation program. This includes a command-directed examination of a specified individual to determine a member's competency for duty or to ascertain whether a member requires counseling, treatment, or rehabilitation for drug abuse.

d. Medical. Any other examination ordered by medical personnel for a valid medical purpose under reference (h), including emergency medical treatment, periodic physical examinations, and such other medical examinations as are necessary for diagnostic or treatment purposes.

5. Number of specimens tested: For each category listed under "Occasion for test," indicate the number of urine specimens submitted for which laboratory processing and reporting was completed during the reporting period. Those specimens submitted in one period and processed in another shall be reported in the later period. Note that specimens, not individuals, are counted; an individual who is tested more than once is reported for each specimen submitted. Use the "Polydrug" category to indicate those specimens found to contain two or more drugs.

6. Authentication of report: Indicate the name, title, and telephone number of the individual who is preparing the report and is responsible for its accuracy. Also, indicate the date the report is forwarded.

Aug 4, 83
1010.3 (Encl 5)

FORMAT FOR
REPORT ON MILITARY LAW ENFORCEMENT ACTIVITY
(RCS DD-HA(Q)1586)

1. Military Service:

2. Reporting period (from YYMMDD to YYMMDD):

3. Geographic area:

	4. NUMBER OF IDENTIFIED OFFENDERS				
5. Type of Offense	Active duty military personnel	Federal civilian employees	Family members	Other	Nonactive duty military personnel
Use or possession					
Opiates					
Cannabis					
Other drugs					
Distribution					
Opiates					
Cannabis					
Other drugs					
Manufacture					
Opiates					
Cannabis					
Other drugs					
Driving while intoxicated (DWI)					
Other alcohol-related traffic offenses					
6. Suspension or revocation of driving privileges					

7. Drug Seizures
Type of drugs seized:
Quantity seized:

8. Name and title of individual preparing report (Last, First, MI):

Telephone number (include area code):

Date submitted (YYMMDD):

INSTRUCTIONS FOR RCS DD-HA(Q)1586

REPORT ON MILITARY LAW ENFORCEMENT ACTIVITY

1. Military Service: Identify by name the Military Service submitting the report.

2. Reporting period: Quarterly, as described in subsection F.2., basic Directive.

3. Geographic area: The geographic areas are described in subsection F.5., basic Directive.

4. Number of identified offenders: List the number of members, by category, who are involved in the use or possession of drugs, distribution of drugs, manufacture of drugs, driving while intoxicated (DWI), or having an alcohol-related traffic offense other than DWI and who are brought to the attention of military law enforcement authorities. They are counted after the investigation is completed, regardless of the final disposition. An individual apprehended when more than one drug offense has taken place shall be listed only once, and then only for the most serious offense. The categories of active duty military personnel and federal civilian employees are self-evident. The category "Family members" includes dependents of active duty and retired military personnel and active duty federal civilian employees. "Other" includes retired military, foreign military, and civilians who are not federal civilian employees or dependents. The column "Nonactive duty military personnel" contains the total for the three columns that immediately precede it. (Note: The "Active duty military personnel" column values are not to be included here.)

5. Type of Offense. The meaning of the terms "Use or possession, distribution, and manufacture," are the same as the definitions of these specific offenses under Chapter 28 of the Manual for Courts-Martial, United States (reference (i)). The term DWI is defined as operating a motor vehicle with a blood alcohol content of .10 or higher. All other traffic offenses that involve misuse of alcohol are to be categorized under the heading "Other alcohol-related traffic offenses."

6. Suspension or revocation of driving privileges: Tally the number of driving privilege suspensions or revocations on the military installation as a result of alcohol- or drug-related offenses.

7. Drug Seizures: Indicate type of drugs seized and quantity seized. For each of the seized drugs listed, indicate the quantity by weight or number.

8. Authentication of report: Indicate the name, title, and telephone number of the individual who is preparing the report and is responsible for its accuracy. Also, indicate the date the report is forwarded.

Aug 4, 83
1010.3 (Encl 6)

FORMAT FOR
REPORT ON CLIENTS IN TREATMENT OR REHABILITATION FOR DRUG OR ALCOHOL ABUSE
(RCS DD-HA(Q)1587)[1]

1. Military Service:
2. Reporting period (from YYMMDD to YYMMDD):
3. Type of report (check one): _____Drug abuse _____Alcohol abuse

4. Geographic area:

5. Initial Screening:
   a. Referred to commander or supervisor _____
   b. Referred for motivational education _____
   c. Drug or alcohol abusers referred for treatment and rehabilitation _____
   d. Total number screened _____

6. and 7. Treatment and Rehabilitation:
(see definitions on reverse side)

Clients	Medical Treatment	Rehabilitation Resident	Rehabilitation Nonresident
a. Beginning of period			
b. Referred during period			
c. Disposition during period			
(1) Program successfully completed			
(a) Returned to duty			
(b) Separated upon completion			
(2) Program not completed			
(a) Separated - (drug-) (alcohol-) related			
(b) Separated - misconduct not (drug-) (alcohol-) related			
(c) ETS			
(d) Transfer to VA or other civilian program			
(e) Other*			
d. End of period			

8. Number of treatment and rehabilitation facilities:
   a. Medical
   b. Resident (centralized)
   c. Nonresident (local)

9. *Number of other clients:	Entering treatment and rehabilitation	Leaving treatment and rehabilitation
a. Dependents of active duty military personnel		
b. Dependents of retired military		
c. Dependents of DoD civilian employees		

10. Name and title of individual preparing report (Last, First, MI):

Telephone number (include area code):

Date submitted (YYMMDD):

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[1] Formerly DD-H&E(M)1194 and DD-H&E(Q)1330

Aug 4, 83
1010.3 (Encl 6)

INSTRUCTIONS FOR RCS DD-HA(Q)1587

REPORT ON CLIENTS IN TREATMENT OR REHABILITATION
FOR DRUG OR ALCOHOL ABUSE

1. Military Service: Identify by name the Military Service submitting the report.

2. Reporting period: Quarterly, as described in subsection F.2., basic Directive.

3. Type of report: Indicate whether the report concerns drug or alcohol abuse by checking the appropriate item. A separate report shall be submitted for each category of abuse.

4. Geographic area: The geographic areas are described in subsection F.5., basic Directive.

5. Initial screening: Screening of a military drug or alcohol user to determine the course of action to be taken, if any. There are some service members whose use of drugs or alcohol is so minor that referral to an education program or commander or supervisor for possible disciplinary action will be sufficient. Others may require some measure of medical treatment or rehabilitative care.

a. Indicate the number of individuals referred to their commander or supervisor because no specific rehabilitation action was necessary.

b. Indicate the number of service members referred for motivational education. If an individual is referred to his or her commander or supervisor and for motivational education, list under special education.

c. Indicate the number of drug or alcohol abusers referred for treatment and rehabilitation. This figure will be identical to the total found under "Treatment and Rehabilitation," in the section "Referred during period" (resident and nonresident).

d. Indicate the total number of military personnel screened during this period.

6. Definitions:

a. A medical treatment patient. Receives medical treatment in a military medical treatment facility for a primary diagnosis of drug or alcohol abuse. The drug diagnostic codes (International Classification of Diseases--9th Revision) in this category are the 292 series, Drug Psychoses; and 304 series, Nondependent Use of Drugs. The alcohol diagnostic codes are the 291 series, Alcoholic Psychoses; 303 series, Alcohol Dependence Syndrome; 425.5, Alcoholic Cardiomyopathy; 571.0, Alcoholic Fatty Liver; 571.1, Acute Alcoholic Hepatitis; 571.2, Alcohol Cirrhosis of Liver; and 571.3, Alcoholic Liver Damage, Unspecified.

b. A rehabilitation client. Registered in either a resident or nonresident program.

(1) A resident client. In residence at a live-in, military drug abuse rehabilitation facility established to treat drug abuse. It may or may not be a part of a medical treatment facility and normally is a centralized facility where clients are sent from their duty assignment.

(2) A nonresident client. Is being treated in an authorized, nonlive-in, military drug abuse program other than in a medical patient or resident status, such as an individual on active duty with his or her unit and undergoing rehabilitation counseling. Normally, this facility is located at the client's duty station.

7. Treatment and Rehabilitation: Indicate the number of military personnel involved in either medical treatment or rehabilitation.

a. Beginning of period: The number should be the same as that submitted for "End of period" in the preceeding reporting period.

b. Referred during period: Drug or alcohol abusers referred for care as identified in paragraph 5.d., above.

c. Disposition during period: This total is the number of members reported under "Program successfully completed," "Program not completed," and "Other."

(1) Program successfully completed: Indicates the total number of members who are returned to duty or separated from Military Service and whose treatment or rehabilitation phase is considered successful, according to Military Service criteria.

(a) Returned to duty: This indicates the number of members whose treatment or rehabilitation phase is completed and who are returned to duty.

(b) Separated upon completion: This indicates the number of members whose treatment or rehabilitation phase is completed, but who are separated from the Military Service because their enlistment or appointment has expired.

(2) Program not completed: Indicates the total number of members obtained from the following areas: separated - (drug-) (alcohol-) related, separated - misconduct not (drug-) (alcohol-) related, reached Estimated Time of Separation (ETS), transfer to Veterans Administration (VA), and other. Depending on the type of report submitted, delete either (drug-) or (alcohol-) for subparagraphs (a) and (b), below.

(a) Separated - (drug-) (alcohol-) related: Indicates the number of members who were separated from Military Service for a drug- or alcohol-related problem.

(b) Separated - misconduct not (drug-) (alcohol-) related: Indicates the number of members who were separated from Military Service for a nondrug- or nonalcohol-related conduct problem.

(c) ETS: Indicates the number of individuals who did not complete the program because their term of military service expired.

(d) Transfer to VA or other civilian program: Indicates the number of members who were referred to a Veterans Administration facility or to a civilian program.

(e) Other: Indicates the total number of members whose disposition during the period is different from those listed under paragraph 7.c., above, such as AWOL and death. Annotate the reasons at the bottom of the report form or use a continuation sheet.

d. End of period: Indicates the number of members in treatment or rehabilitation at the end of the period. This is obtained by adding the number of members at the beginning of the period and the number of members referred during the period, and then subtracting the number of members who left the program during the period.

8. Number of treatment and rehabilitation facilities: Indicates by category the number of treatment and rehabilitation facilities used for drug and alcohol abuse clients. Make a footnote when the same treatment or rehabilitation facilities, by number and category, are used for both drug and alcohol abuse treatment.

9. Number of other clients: Indicates members of dependents of active duty military personnel, dependents of retired military personnel and dependents of DoD civilian employees entering or leaving treatment and rehabilitation during the reporting period. Personnel who are DoD civilian employees should not be counted here.

10. Name, title, and telephone number of individual who is preparing this report and is responsible for its accuracy. Also, indicate the date the report is forwarded.

Aug 4, 83
1010.3 (Encl 7)

FORMAT FOR
LEGAL OR ADMINISTRATIVE
DISPOSITION OF DRUG ABUSE OFFENDERS
(RCS DD-HA(Q)933)[1]

1. Military Service:

2. Reporting period (from YYMMDD to YYMMDD):

3. Geographic area:

	Use or possession	Distribution	Manufacture	Total
4. Number of nonjudicial punishments				
5. Number of general courts-martial Discharges/Dismissals				
6. Number of special courts-martial Discharges/Dismissals				
7. Number of summary courts-martial				
8. Number of administrative separations in lieu of courts-martial				
9. Number of separations for rehabilitation failures				
10. Number of other administrative separations for drug abuse				

11. Name and title of individual preparing report (Last, First, MI):

Telephone number (including area code):

Date submitted (YYMMDD):

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[1] Formerly DD-M-(SA)933

Aug 4, 83
1010.3 (Encl 7)

INSTRUCTIONS FOR RCS DD-HA(Q)933

LEGAL OR ADMINISTRATIVE DISPOSITION OF DRUG ABUSE OFFENDERS

1. Military Service: Identify the Military Service submitting the report.

2. Reporting period: Quarterly, as described in subsection F.2., basic Directive.

3. Geographic area: The geographic areas are described in subsection F.5., basic Directive.

4. Number of nonjudicial punishments: Indicate the number of instances of nonjudicial punishment under Article 15 of the Manual for Courts-Martial, United States (reference (i)), when one or more of the offenses was for the use or possession, distribution (including introduction), or manufacture of a dangerous drug. Intent offenses should also be categorized as above.

5. Number of trials by court-martial: Indicate the number of general court-martial convictions in whole or in part involving the use or possession, distribution, or manufacture of dangerous drugs. Report this figure as of when the court is approved. Also, indicate the number of courts-martial that approved the discharge or dismissal of the service member before the automatic review process.

6. Number of special courts-martial: Indicate the number of special court-martial convictions in whole or in part involving the use or possession, distribution, or manufacture of dangerous drugs. Report this figure as of when the court is approved. Also, indicate the number of courts-martial that approved the discharge or dismissal of the service member before the automatic review process.

7. Number of summary courts-martial: Indicate the number of summary court-martial convictions for use or possession, distribution, or manufacture of dangerous drugs.

8. Number of administrative separations in lieu of courts-martial: Indicate the number of administrative separations in lieu of courts-martial in whole or in part involving the use or possession, distribution, or manufacture of dangerous drugs.

9. Number of separations for rehabilitation failure: Indicate the number of separations resulting in whole or in part from the service member's failure in a drug rehabilitation program.

10. Number of other administrative separations for drug abuse: Indicate the number of misconduct separations resulting in whole or in part from the use or possession, distribution (including introduction), or manufacture of dangerous drugs.

11. Name, title, and telephone number of individual who is preparing report and is responsible for its accuracy. Also, indicate the date the report is forwarded.

FORMAT FOR
REPORT ON CIVILIAN EMPLOYEE ALCOHOL AND DRUG ABUSE
(RCS DD-HA(Q)1627)

1. GENERAL INFORMATION

   a. Reporting period (from YYMMDD to YYMMDD):

   b. Date submitted (YYMMDD):

   c. Submitting DoD Component:

   d. Name, title, and telephone number (including area code) of individual preparing report (Last, First, MI):

   e. Total number of employees:

   f. Geographic area:

2. COUNSELING DATA

	Alcohol	Drugs	Emotional
a. Number of new or reopened cases			
b. Number of cases helped			
c. Number of cases not helped			
d. Number of cases too early to judge			
e. Number of self-referrals			
f. Number of supervisory referrals			

3. LEVEL OF EFFORT

   a. Total number of staff members:
      Full time:
      Part time:

   b. Total staff years:

   c. Budgeted operating costs:

4. EDUCATION AND TRAINING INFORMATION

Type	Number	Hours
a. Mandatory new employee orientation		
b. Mandatory supervisor training		
c. Mandatory program staff training		
d. Optional family member education		
e. Other (specify)		

Aug 4, 83
1010.3 (Encl 8)

INSTRUCTIONS FOR RCS DD-HA(Q)1627
REPORT ON CIVILIAN EMPLOYEE ALCOHOL AND DRUG ABUSE

1. General information

a. Reporting period: Quarterly, as described in subsection F.2., basic Directive.

b. Date submitted: The date the report is forwarded to this office.

c. Submitting DoD Component: Military Service or Defense Agency.

d. Name, title, and telephone number of individual who is preparing this report and is responsible for its accuracy.

e. Total number of employees: Total U.S. citizen civilian employees within the reporting Military Service or Defense Agency.

f. Geographic area: The geographic areas are described in subsection F.5., basic Directive.

2. Counseling data

a. Number of new or reopened cases: Indicates number of cases by category (alcohol, drugs, or emotional). A case equates to a person counseled or referred for counseling to an outside source. This number shall equal the total of self-referrals and supervisory referrals.

b. Number of cases helped: Indicate the number of cases by category. These are cases when the client, supervisor, or counselor reports that the problem was resolved (job performance is at an acceptable level).

c. Number of cases not helped: Indicate the number of cases by category. These are cases when the client's problem was not resolved (job performance is unacceptable).

d. Number of cases too early to judge: Indicate the number of cases by category. This incudes those cases when job performance has improved, but is not yet at an acceptable level.

e. Number of self-referrals: Those clients who sought help themselves, but were not officially referred.

f. Number of supervisory referrals: Those clients officially referred for help.

3. Level of effort

a. Total number of staff members: Number of civilian employees with a duty assignment (full-time or part-time) providing drug or alcohol services for civilian employees. These duties include: policy development, administration, education and training, consultation, problem assessment, and counseling and followup.

b. Total staff years: Number of staff years devoted to the Military Service or Defense Agency program by staff members in providing drug and alcohol services for civilian employees.

c. Budgeted operating costs: Report only those costs that appear in an approved budget designated for civilian alcohol and drug programs.

4. Education and training information

a. Mandatory new employee orientation: Report the number of employees receiving orientation and the average amount of time expended per session.

b. Mandatory supervisor training: Report the number of supervisors receiving training and the average amount of time expended per session.

c. Mandatory program staff training: Report the number of staff personnel receiving training and the average amount of time expended for training.

d. Optional family member education: Report the number of civilian employee family members who attended education programs.

e. Other (specify): Report other types of education and training information programs being conducted that are alcohol or drug related.

August 10, 1983
NUMBER 1010.7

Department of Defense Directive ASD(HA)

SUBJECT: Drunk and Drugged Driving by DoD Personnel

References: (a) Secretary of Defense Memorandum, "Driving While Intoxicated (DWI)," November 26, 1982 (hereby canceled)
(b) DoD Instruction 1010.5, "Education and Training in Alcohol and Drug Abuse Prevention," December 5, 1980
(c) Federal Personnel Manual Chapter 930, "Programs for Specific Positions and Examinations" (Subchapters 1-16)
(d) Federal Personnel Manual System Supplement 792-2, "Alcohol and Drug Abuse Programs," Installment One, February 29, 1980
(e) through (i), see enclosure 1

A. PURPOSE

This Directive:

1. Establishes DoD policy regarding drunk and drugged driving by DoD personnel (hereafter referred to as "intoxicated driving").

2. Assigns responsibility for and explains DoD policy and procedures on the establishment and operation of the DoD Intoxicated Driving Prevention Program, which is designed to address the problem of and increase the awareness and attention given to intoxicated driving by DoD personnel.

3. Establishes the DoD Intoxicated Driving Prevention Task Force (DIDPTF).

4. Cancels reference (a).

B. APPLICABILITY

This Directive applies to the Office of the Secretary of Defense, the Military Departments, the Organization of the Joint Chiefs of Staff, the Unified and Specified Commands, and the Defense Agencies (hereafter referred to collectively as "DoD Components"). The term "Military Services," as used herein, refers to the Army, Navy, Air Force, and Marine Corps.

C. DEFINITIONS

Terms used in this Directive are defined in enclosure 2.

Enclosure 5

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D. POLICY

1. Intoxicated driving is incompatible with the maintenance of high standards of performance, military discipline, DoD personnel reliability, and readiness of military units and supporting activities. It is DoD policy to reduce significantly the incidence of intoxicated driving within the Department of Defense through a coordinated program of education, identification, law enforcement, and treatment. Specifically, the goal of the DoD Intoxicated Driving Prevention Program is to reduce the number of fatalities and injuries suffered by DoD personnel and the amount of property damage that result from intoxicated driving. Persons who engage in intoxicated driving, regardless of the geographic location of the incident, have demonstrated a serious disregard for the safety of themselves and others. It is appropriate for military commanders, in the exercise of their inherent authority, to protect the mission of an installation and the safety of persons and property therein to restrict driving privileges of persons who engage in such actions.

2. The Department of Defense shall participate in the national effort to prevent intoxicated driving by maintaining appropriate relationships with other governmental agencies and private organizations and shall cooperate with responsible civil authorities consistent with statutory and regulatory constraints in detecting, identifying, apprehending, prosecuting, educating, and counseling intoxicated drivers and in reporting cases as required by state laws and applicable Status of Forces Agreements.

E. PROCEDURES

1. Education and Training

a. The Military Services shall provide drug and alcohol education that focuses on intoxicated driving for each of the following: law enforcement, public information, emergency room, and safety personnel. Club managers, bartenders, and waitresses serving alcoholic beverages and Class VI or package sales personnel shall receive annual refresher training. In addition, leadership curricula at all levels (PCO/PXO indoctrination, training for judge advocates and military judges, and officer and noncommissioned officer schools) shall include specific information and a review of current Military Service policy on intoxicated driving.

b. Other DoD Components shall provide similar instruction in conjunction with the training and education requirements of DoD Instruction 1010.5 (reference (b)).

c. DoD Components shall cooperate, to the extent feasible and permitted by law and regulation, with community leaders and existing grassroots organizations that are working to combat intoxicated driving, in planning and implementing local education efforts.

2. Suspension of Driving Privileges. Each DoD Component or its supporting agency that regulates driving privileges shall establish procedures for mandatory suspension of driving privileges on military installations and in areas subject to military traffic supervision. They shall establish procedures for

acquiring arrest reports and other official documentation of intoxicated driving incidents consistent with applicable laws and regulations. Such procedures shall be sufficiently flexible to meet local needs.

a. Military personnel and their family members, retired members of the Military Services, DoD civilian personnel, and others with installation driving privileges may have those driving privileges suspended, regardless of the geographic location of an intoxicated driving incident.

(1) Suspension is authorized for non-DoD civilians only with respect to incidents occurring on the military installation or in areas subject to military traffic supervision.

(2) With respect to DoD civilian personnel covered by a negotiated agreement, a suspension under this subsection may be reviewed only to the extent required by the negotiated agreement applicable to the affected employee. Such matters mandatorily are excluded from DoD Component administrative grievance procedures. A grievance under such a procedure will not delay imposition of a preliminary or 1-year suspension of driving privileges.

(3) A notice of suspension will not become effective until 24 hours after the incident for which a suspension is imposed. However, this provision does not preclude appropriate action to prevent an intoxicated person from operating a motor vehicle, nor does it affect the validity of an earlier suspension imposed on the same individual.

(4) A hearing authorized under paragraph E.2.b., E.2.c., or E.2.e., below, shall be conducted by the installation commander. The power to conduct a hearing and make a decision may be delegated only to an official whose primary duties are not in the field of law enforcement. At a hearing under this subsection, the individual shall have the right to present evidence and witnesses at his or her own expense. The individual may be represented by counsel at his or her own expense. DoD civilian personnel may have a personal representative present in accordance with applicable laws and regulations.

b. <u>Suspension Based upon Lawful Apprehension</u>

(1) Preliminary suspension of driving privileges is mandatory based upon an arrest report or other official documentation of the circumstances of an apprehension for intoxicated driving.

(2) The individual shall be notified in writing of the preliminary suspension. The notice shall include the arrest report or other documentation and shall inform the individual that a 1-year suspension can be imposed upon conviction, imposition of nonjudicial punishment, or action by civilian authorities leading to suspension or revocation of the individual's driver's license. The notice shall inform the individual that he or she has the right to submit a request within 5 working days to vacate the preliminary suspension and that failure to request such a hearing will result in continuation of the preliminary suspension.

(3) If a hearing has not been requested within 5 working days, the preliminary suspension shall be continued until there has been a criminal, nonjudicial, or administrative disposition.

(4) If the individual requests a hearing to vacate the preliminary suspension, it shall be held within 10 working days of the request. If the official conducting the hearing determines that the apprehension was based upon probable cause, the preliminary suspension shall be continued; if not, it shall be vacated. Such determinations are solely for purposes of acting on the preliminary suspension and are without prejudice to the rights of any party in a subsequent criminal or administrative proceeding involving the same or a related incident.

(5) If the individual is acquitted, the charges are dismissed, or there is an equivalent determination in a nonjudicial punishment proceeding or civilian administrative action, the preliminary suspension shall be vacated.

(6) If there is a conviction, nonjudicial punishment, or civil suspension or revocation of driving privileges, the suspension shall be continued for 1 year from the date of the original preliminary suspension. Such action shall be taken only on the basis of an official report.

c. Suspension for Refusal to Take a Blood Alcohol Content (BAC) Test

(1) Preliminary suspension of driving privileges is mandatory based upon an official report that an individual refused to submit to a lawfully requested BAC test.

(2) The individual shall be notified of the preliminary suspension in writing. The notice shall include the arrest report or other documentation and shall inform the individual that a 1-year suspension can be imposed after a hearing under subparagraph E.2.c.(4), below. The notice also shall inform the individual that he or she has the right within 5 working days to submit a request for a hearing to validate the preliminary suspension and that the suspension will be for 1 year if a hearing is not requested.

(3) If a hearing is not requested within 5 working days, the suspension shall be for 1 year.

(4) If the individual requests a hearing to vacate the preliminary suspension, it shall be held within 10 working days of the request. The hearing shall consider the arrest report or other official documentation, information presented by the individual, and such other information as the hearing officer may deem appropriate. The official conducting the hearing shall consider the following issues: (a) Did the official have reasonable grounds to believe that the person had been operating, or was in actual physical control of, a motor vehicle while intoxicated? (b) Was the person lawfully cited or apprehended for an intoxicated driving offense? (c) Was the individual lawfully requested to submit to a BAC test? (d) Did the person refuse to submit to or fail to complete a BAC test required by the law of the jurisdiction in which the test was requested? If, in view of these issues, the test was lawfully requested, the suspension shall be for 1 year, irrespective of the ultimate disposition of the underlying intoxicated driving offense. If not, the preliminary suspension shall be vacated. Such determinations are solely for purposes of acting on the preliminary suspension and are without prejudice to the rights of any party in a subsequent criminal or administrative proceeding involving the same or a related incident.

d. Suspension upon Conviction, Nonjudicial Punishment, or Civilian Administrative Action

(1) Suspension of driving privileges for 1 year is mandatory when there has been a conviction, nonjudicial punishment, or civilian revocation or suspension of driving privileges for intoxicated driving, regardless of any prior administrative determination under paragraph E.2.b., E.2.c., or E.2.e.

(2) Such action shall be taken only on the basis of an official report.

(3) The individual shall be notified in writing of the suspension and shall be notified that an exception may be granted only under paragraph E.2.f., below.

(4) The suspension shall be issued by the installation commander. This authority may be delegated only to an official whose primary responsibilities are not in the field of law enforcement.

e. Repeat Offenders

(1) Preliminary increase in suspension of driving privileges is mandatory based upon an arrest report or other official documentation of an individual's driving in violation of a suspension imposed under this Directive or under similar rules previously issued by a DoD Component.

(a) The individual shall be notified in writing of the preliminary increase in suspension. The notice shall include the arrest report or other documentation of the violation as well as documentation of the original suspension and shall inform the individual that his or her original suspension can be increased by 2 years after a hearing under subparagraph E.2.e.(1)(c), below. The notice shall inform the individual that he or she has the right within 5 working days to submit a request for a hearing to vacate the preliminary increase in suspension and that the original suspension will be increased by 2 years if such a request is not submitted.

(b) If a hearing has not been requested within 5 working days, the original suspension shall be increased by 2 years.

(c) If the individual requests a hearing to vacate the preliminary suspension, it shall be held within 10 working days of the request. The hearing shall consider the arrest report or other official documentation, information presented by the individual, documentation of the original suspension, and such other information as the hearing officer may deem appropriate. If the official conducting the hearing determines that the allegation of driving in violation of a suspension is supported by a preponderance of the evidence, the original suspension shall be increased by 2 years. If not, the preliminary increase in suspension shall be vacated. Such determinations are without prejudice to the rights of any party in a subsequent criminal or administrative proceeding involving the same or a related incident.

(d) If in a subsequent judicial, nonjudicial, or administrative proceeding, it is determined that the individual did not violate a suspension, the preliminary increase in suspension shall be vacated.

(2) For each subsequent determination within a 5-year period that a 1-year suspension is authorized under paragraphs E.2.b. through E.2.d., above, driving privileges shall be suspended for 2 years. Such period shall be in addition to any suspension previously imposed. Military personnel shall be prohibited from obtaining or using a U.S. Government Motor Vehicle Operator's Identification Card, Standard Form (SF) 46, for 6 months for each such incident. A determination whether DoD civilian personnel should be prohibited from obtaining or using an SF 46 shall be made under Federal Personnel Manual Chapter 930 (reference (c)) and other laws and regulations applicable to civilian personnel. Nothing in this subsection precludes an installation commander from imposing a prohibition upon obtaining or using an SF 46 for a first offense or for such other reasons as may be authorized under applicable laws and regulations.

f. Exceptions

(1) Exceptions to the mandatory suspension provisions in this Directive may be granted under regulations by the DoD Component concerned on a case-by-case basis. Requests for exceptions shall be in writing. Such exceptions may be granted only on the basis of:

(a) Mission requirements;

(b) Unusual personal or family hardship; or

(c) In the case of a preliminary suspension following lawful apprehension, delays exceeding 90 days in the formal disposition of the allegations insofar as such delays are not attributable to the individual.

(2) With respect to a person who has no reasonably available alternate means of transportation to officially assigned duties, a limited exception shall be granted for the sole purpose of driving directly to and from such duties. This does not authorize a person to drive on a military installation if the person's driver's license is under suspension or revocation by a state, federal, or host country civil court or administrative agency. Maximum reliance shall be placed on carpools, public transportation, and reasonably available parking facilities adjacent to the installation before such a limited exception is granted. Nothing in this provision precludes appropriate or other administrative action on the basis of an intoxicated driving incident or driving in violation of a previously imposed suspension.

(3) Exceptions granted under this paragraph shall be reported in writing to the next official in the chain of command.

g. Overseas commanders with authority to issue driver's licenses shall establish procedures for suspension of such licenses for intoxicated driving. Such procedures, insofar as the commanders deem practicable, shall be similar to the procedures for suspension of installation driving privileges prescribed in paragraphs E.2.a. through f., above.

h. Persons whose installation driving privileges are suspended for 1 year or more under paragraph E.2.b., E.2.c., or E.2.d., above, shall complete an alcohol or drug safety action program or equivalent alcohol education course (minimum of 8 hours) before their installation driving privileges may be reinstated.

3. Screening. Each DoD Component or its supporting agency shall establish procedures for screening military personnel charged with intoxicated driving offenses within 7 working days of issuance of notice of the preliminary suspension to determine whether a member is dependent on alcohol or other drugs. The results of this screening shall be made available to the command having jurisdiction over the case before adjudication. Information concerning personal alcohol and drug abuse provided by a member in response to screening questions may not be used against the member in a court-martial or on the issue of characterization in an administrative separation proceeding. Nothing in this provision precludes introduction of such evidence for other administrative purposes or for impeachment or rebuttal purposes in any proceeding in which evidence of alcohol or drug abuse (or lack thereof) first has been introduced by the member, nor does it preclude disciplinary or other action based on independently derived evidence. DoD civilian personnel charged with intoxicated driving shall be advised of the Civilian Employee Assistance Program or Installation Drug and Alcohol Program and the availability of evaluation in accordance with Federal Personnel Manual Supplement 792-2 (reference (d)). Retired members of the Military Services shall be advised of the availability of evaluation and treatment programs.

4. Notification of State Driver's License Agencies. Each DoD Component or its supporting agency shall establish a systematic procedure in accordance with DoD Directive 5400.11 (reference (e)) to notify state driver's license agencies of DoD personnel whose installation driving privileges are suspended for 1 year or more following final adjudication of the intoxicated driving offense or upon suspension for refusal to submit to a lawful BAC test under subsection E.2., above. This notification shall include the basis for the suspension and the BAC level, if known. Exceptions shall be made only when such a suspension was increased for an additional 2 years for driving on an installation while installation driving privileges were suspended solely on the basis of driving in violation of suspension (see paragraph E.2.e., above). This notification shall be sent to the state in which the driver's license was issued and the state in which the installation is located. Sample letter format is provided in enclosure 3, and state driver's license agencies are listed in the attachment to the enclosure. DoD Components shall establish a system to exchange intoxicated driving and driving privilege suspension data when DoD personnel transfer from one location to another to ensure that the receiving installation continues any remaining portion of the suspension. This information requirement is exempt from formal approval and licensing.

5. The Military Services shall include the intoxicated driving prevention program as an inspection item of special interest for Inspector General or administrative inspections.

6. The Military Services shall direct installation commanders to assess the availability of drugs and alcohol in the vicinity of military installations through their Armed Forces Disciplinary Control Boards or Control Boards of

other appropriate federal agencies. Whenever the availability of alcohol or drugs, or both, at an establishment off-base presents a threat to the discipline, health, and welfare of DoD personnel, such establishments shall be dealt with as prescribed in the "Armed Forces Disciplinary Control Board and Off-Installation Military Enforcement Guidance" (Army Regulation No. 190-24, Marine Corps Order No. 162.2A, BUPERS Inst. 1620.4A, Air Force Regulation No. 125-11, Commandant Instruction No. 1620.13).

7. Cases Involving Death or Serious Injury

a. To the extent permitted by law and consistent with the Uniform Code of Military Justice (UCMJ) and the "Manual for Courts-Martial" (references (f) and (g)) and in accordance with trial counsel's judgment of appropriate tactical and ethical concerns, consideration shall be given to presenting a victim's impact statement (oral or written statement by victims or survivors) before sentencing in cases involving intoxicated driving.

b. Trial counsel are encouraged to make reasonable efforts to ensure that the victim or the victim's family is provided information about the progress and disposition of cases processed under reference (f).

8. DoD Components with field installations shall establish an awards and recognition program to recognize successful local installation intoxicated driving prevention programs.

9. Each DoD Component or its supporting agency is encouraged to use, as guidance, "Report on a National Study of Preliminary Breath Test (PBT) and Illegal Per Se Laws" (reference (h)) and "Interim Report to the Nation by the Presidential Commission on Drunk Driving" (reference (i)).

F. RESPONSIBILITIES

1. The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) shall:

a. Develop a coordinated approach to the reduction of intoxicated driving, consistent with this Directive, recognizing that intoxicated driving prevention programs shall be designed to meet local needs.

b. Appoint the chair of the DIDPTF.

c. Monitor Military Service and DoD Component regulations that implement the DoD Intoxicated Driving Prevention Program.

d. Act as focal point for the Department of Defense for interagency and nongovernmental coordination of national intoxicated driving prevention programs.

e. Evaluate and report biennially to the Secretary of Defense on the effectiveness and efficiency of the DoD Intoxicated Driving Prevention Program.

2. The Assistant Secretary of Defense (Manpower, Reserve Affairs, and Logistics) (ASD(MRA&L)) shall:

a. Ensure the DoD Dependents Schools system and Section VI schools include specific material in the curriculum (grades 7 through 12) on the effects that alcohol and drugs have on the impairment of driving skills.

b. Ensure that intoxicated driving, accident, mishap, and injury data include:

(1) BAC of drivers in three categories - .01-.04, .05-.09, and .10 and above.

(2) Time of day and day of the week the mishap or injury occurred.

(3) Type of vehicle (include MOPEDs with motorcycle data).

(4) Death and injury data on DoD personnel killed or injured as a result of intoxicated driving, including those who were not intoxicated themselves but were involved in a mishap as a result of intoxicated driving by another party.

(5) Government property damage cost.

(6) Cost of treatment of injured DoD personnel.

(7) Pertinent data on military personnel separated or retired as a result of injury or other action taken because of:

(a) Intoxicated driving by the person being separated or retired; or

(b) Intoxicated driving by another person.

(8) Other chemical substances causing intoxicated driving that contributed to an accident.

c. Provide an annual report to the Secretary of Defense that assesses the impact of intoxicated driving on the Department of Defense. The report shall include intoxicated driving arrest, apprehension, and conviction data as well as the number of exceptions granted to the mandatory suspension of driving privileges under paragraph E.2.f., above.

d. Establish procedures (when feasible) under which DoD personnel convicted for driving while intoxicated will pay administrative restitution to the government for property damage or medical expenses to the extent permitted by applicable law.

e. Amend appropriate DoD issuances to include the use of a preliminary or prearrest breath test (PBT) to be used by law enforcement personnel to indicate impairment when the arresting officer has reason to believe the operator of a motor vehicle may be intoxicated. (See "Report on a National Study of Preliminary Breath Test (PBT) and Illegal Per Se Laws," reference (h)).

3. The Head of Each DoD Component or Its Supporting Agency shall establish and operate intoxicated driving prevention programs prescribed by this Directive.

G. DOD INTOXICATED DRIVING PREVENTION TASK FORCE

1. Organization and Management

a. The DIDPTF shall be chaired by a representative of the Deputy Assistant Secretary of Defense (Health Promotion), Office of the ASD(HA).

b. The DIDPTF shall consist of representatives of the Military Services' drug and alcohol programs and law enforcement communities and a representative of the Deputy Assistant Secretary of Defense (Equal Opportunity and Safety Policy), Office of the ASD(MRA&L).

c. Meetings generally shall be held bimonthly; however, special sessions may be required by the chair.

2. Functions. The DIDPTF shall:

a. Monitor Military Service and DoD Component policy as it applies to the prevention of intoxicated driving.

b. Review programs and policy developed by other federal and state agencies and make recommendations of suitable adaptation within the Department of Defense.

c. Make recommendations to the ASD(HA) and the ASD(MRA&L) on matters pertaining to intoxicated driving.

H. INFORMATION REQUIREMENTS

Information requirements of this Directive are prescribed in subsection E.4. and paragraphs F.1.e. and F.2.c., above.

I. EFFECTIVE DATE AND IMPLEMENTATION

This Directive is effective immediately. Forward two copies of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days.

Caspar W. Weinberger
Secretary of Defense

Enclosures - 3
1. References
2. Definitions
3. Driver's License Information

REFERENCES, continued

(e) DoD Directive 5400.11, "Department of Defense Privacy Program," June 9, 1982
(f) Title 10, United States Code, Chapter 47 (Uniform Code of Military Justice)
(g) "Manual for Courts-Martial," United States, 1969 (revised edition)
(h) "Report on a National Study of Preliminary Breath Test (PBT) and Illegal Per Se Laws," August 1961[1]
(i) "Interim Report to the Nation by the Presidential Commission on Drunk Driving," December 13, 1982[2]

[1] Available from the National Technical Information Service, Springfield, Virginia 22161. Publication number DOT HS-806-048.
[2] Available from the Presidential Commission on Drunk Driving, Room 4109, 400 7th St. SW, Washington, D.C. 20590.

DEFINITIONS

1. Blood Alcohol Content (BAC). The percentage, by weight, of alcohol in a person's blood as determined by blood, urine, or breath analysis. Percent of weight by volume of alcohol in the blood is based on grams of alcohol per 100 milliliters of blood.

2. Conviction. An official determination or finding as authorized by state or federal law or regulation, including a final conviction by a court or court-martial (whether based on a plea of guilty or a finding of guilty and regardless of whether the penalty is rebated, deferred, suspended, or probated), an unvacated forfeiture of bail or other collateral deposited to secure a defendant's appearance in court, a plea of nolo contendere accepted by a court, or a payment of a fine.

3. DoD Issuances. DoD Directives, Instructions, publications, and changes thereto.

4. DoD Personnel

a. Civilian Personnel. Employees of the Department of Defense whose salary or wages are paid from appropriated or nonappropriated funds.

b. Military Personnel. All U.S. military personnel on active duty, U.S. military reserve or National Guard personnel on active duty, and Military Service academy cadets.

5. Driving Privileges. Operation of a privately owned motor vehicle on an installation or in areas where traffic operations are under military supervision.

6. Intoxicated Driving. Includes one or more of the following:

a. Operating a motor vehicle under any intoxication caused by alcohol or drugs in violation of Article 111 of the UCMJ (reference (f)) (see paragraphs 190 and 191 of the "Manual for Courts-Martial," reference (g)) or a similar law of the jurisdiction in which the vehicle is being operated.

b. Operating a motor vehicle with a BAC of .10 or higher on a military installation or in an area where traffic operations are under military supervision.

c. Operating a motor vehicle with a BAC of .10 or higher in violation of the law of the jurisdiction in which the vehicle is being operated.

d. Operating a motor vehicle with a BAC of .05 but less than .10 in violation of the law of the jurisdiction in which the vehicle is being operated if the jurisdiction imposes a suspension or revocation solely on the basis of the BAC level.

7. Supporting Agency. The agency that accepts the responsibility and performs the actions necessary to accomplish any of the requirements of this Directive (for example, one of the Military Services supporting a Defense Agency through installation vehicle registration, screening of intoxicated drivers, or supervisor education).

Aug 10, 83
1010.7 (Encl 3)

DRIVER'S LICENSE INFORMATION (Sample Letter)

FROM: _____
_____
_____

TO: Department of Vehicle Registration and Licenses
_____
_____
_____

SUBJECT: Notification of Person Convicted of an Intoxicated Driving Offense

This letter is your notification that on _____ (date), _____ (last name, first name, middle initial) _____ and social security number of person), a member of _____ (branch of Military Service or DoD Component) _____ (and unit), _____ (installation location), was found guilty of (intoxicated driving or refusal to take a blood alcohol content (BAC) test in a court-martial, non-judicial proceeding under Article 15 of the UCMJ, or civil court). (If civil court, give court name and case number.) (He or she) holds a _____ (state) driver's license, number _____, issued _____, expiring on _____. (He or she) was arrested _____ (date and base location) by _____ (state) (or military) police while driving vehicle license number _____. A BAC test (was or was not) taken (with a reading of _____). Based on the above information, this individual's installation driving privileges have been suspended for (insert number of years). The individual's current address is:

_____
_____
_____

Signer

Aug 10, 83
1010.7 (Att 1 to Encl 3)

STATE DRIVER'S LICENSE AGENCIES

ALABAMA

Data Processing Unit
Driver's Licensing Division
Department of Public Safety
Montgomery, Alabama 36192
(205) 832-5100

ALASKA

MVR Desk
Motor Vehicles
Pouch N
Juneau, Alaska 99811
(907) 465-4361

ARIZONA

Phoenix City Magistrates Court
(No street number required)
Phoenix, Arizona 85001
(602) 262-4001

ARKANSAS

Driver's Control
P.O. Box 1272
Little Rock, Arkansas 72203
(501) 371-1631

CALIFORNIA

Information Services
Department of Motor Vehicles
P.O. Box 11231
Sacramento, California 95813

COLORADO

Motor Vehicle Division
Master File Section 44-489
140 W. 6th Avenue
Denver, Colorado 80204
(303) 866-3751

CONNECTICUT

Assistant Division Chief
60 State Street
Wethersfield, Connecticut 06109
(203) 566-3230

DELAWARE

Senior Clerk
Revocation Section
P.O. Box 698
Dover, Delaware 19901
(302) 736-4427

FLORIDA

Division of Drivers Licenses & Motor Vehicles
Department of Highway Safety
Kirkman Building
Tallahassee, Florida 32301
(904) 488-2117

GEORGIA

Drivers Support Division
Department of Public Safety
P.O. Box 1456
Atlanta, Georgia 30371-2303
(404) 656-5704

HAWAII

Administrator
District Court
1111 Alakea Street
Honolulu, Hawaii 96813
(808) 548-2467

IDAHO

Idaho Transportation Department
Driver Services
P.O. Box 34
Boise, Idaho 83731
(208) 334-2534

ILLINOIS

Abstract Informational Unit
Motor Vehicle Services
2701 S. Dirksen Parkway
Springfield, Illinois 62703
(217) 782-2720

INDIANA

Bureau of Motor Vehicles
Paid Mail Division
State Office Building
Room 416
Indianapolis, Indiana 46204
(317) 232-2894

IOWA

Chief Teletype Operator
Lucas State Office Building
Des Moines, Iowa 50319
(515) 281-5559

KANSAS

Chief
Driver Control Bureau
State Office Building
Topeka, Kansas 66626
(913) 296-3671

KENTUCKY

Division of Driver Licensing
Justice Cabinet
Room 220, State Office Building
Frankfurt, Kentucky 40601
(502) 564-6800

LOUISIANA

Department of Public Safety
Office of Motor Vehicles
P.O. Box 64886
Baton Rouge, Louisiana 70896

MAINE

Driver Record Section
Motor Vehicle Division
Statehouse Station #29
Augusta, Maine 04333
(207) 289-2733

MARYLAND

Director
Driver Records
6601 Ritchie Highway, NE
Glen Burnie, Maryland 21062
(301) 768-7225

MASSACHUSETTS

Registry Motor Vehicles
100 Nashua Street
Boston, Massachusetts 02114

MICHIGAN

Commercial Lookup Unit
Michigan Department of State
Bureau of Driver & Vehicle Services
Lansing, Michigan 48918

MINNESOTA

Driver License Division
108 Transportation Building
St. Paul, Minnesota 55155
(612) 296-2023

MISSISSIPPI

Mississippi Highway Patrol
MVR Section
P.O. Box 958
Jackson, Mississippi 39205
(601) 982-1212, Ext. 268

MISSOURI

Division of Motor Vehicles &
Driver Licensing
P.O. Box 629
Jefferson City, Missouri 65105
(No telephone inquiries)

MONTANA

Office Manager
Driver Services
303 North Roberts
Helena, Montana 59620
(406) 449-3000

NEBRASKA

Administrator
P.O. Box 94789
Lincoln, Nebraska 68509
(402) 471-3888

NEVADA

Driver Record Section
555 Wright Way
Carson City, Nevada 89701
(702) 885-5505

NEW HAMPSHIRE

Department of Safety
Division of Motor Vehicles
Hazen Drive
Concord, New Hampshire 03105
(603) 271-2486

NEW JERSEY

Supervisor, Abstract Section
Dept. of Motor Vehicles
137 E. State Street
Trenton, New Jersey 08625
(609) 292-4558

NEW MEXICO

Chief
Motor Transportation Department
Manuel Lujan Building
Santa Fe, New Mexico 87503
(505) 827-2362

NEW YORK

New York State Dept. of Motor Vehicles
Public Service Bureau
Empire State Plaza
Albany, New York 12228
(518) 474-0705

NORTH CAROLINA

Director
Driver License Section
Division of Motor Vehicles
1100 New Bern Avenue
Raleigh, North Carolina 27697
(919) 733-9906

NORTH DAKOTA

Driving Records
Drivers License Division
600 E. Boulevard
Bismarck, North Dakota 58505
(701) 224-2603

OHIO

Bureau of Motor Vehicles
ATTN: MVOSPA
P.O. Box 16520
Columbus, Ohio 43216

OKLAHOMA

Oklahoma Department of Public Safety
Driver Improvement Division
Box 11415
Oklahoma City, Oklahoma 73136
(405) 427-6541

OREGON

Supervisor
Files and Correspondence DMV
1905 Lana Avenue, NE
Salem, Oregon 97314
(503) 371-2225

PENNSYLVANIA

Division Manager
Citation Processing Division, Room 302
Bureau of Traffic Safety Operations
Department of Transportation
Harrisburg, Pennsylvania 17120

RHODE ISLAND

Department of Motor Vehicles
State Office Building
Providence, Rhode Island 02903
(401) 277-2994

SOUTH CAROLINA

Motor Vehicle Administrator
P.O. Box 1498
Columbia, South Carolina 29216
(803) 758-8428

SOUTH DAKOTA

Driver Improvement Program
118 W. Capitol
Pierre, South Dakota 57501-2080
(605) 773-4128

TENNESSEE

Financial Responsibility Section
P.O. Box 945
Nashville, Tennessee 37202
(615) 741-3954

TEXAS

Director, Motor Vehicle Division
40th and Jackson Avenue
Austin, Texas 78779
(512) 465-7611

UTAH

Chief, Drivers License Bureau
317 State Office Building
Salt Lake City, Utah 84114
(801) 965-4411

VERMONT

Director of Law Administration
Department of Motor Vehicles
120 State Street
Montpelier, Vermont 05603
(Mail inquiries only)

VIRGINIA

Division of Motor Vehicles
Attn: Driver's Licensing and
Information Department
2300 W. Broad Street
Richmond, Virginia 23269
(804) 257-0410

WASHINGTON

Department of Licensing
Driver Services Division
Highway Licensing Building
Olympia, Washington 98504
(206) 753-6976

WEST VIRGINIA

Department of Motor Vehicles
1800 Washington Street, East
Charleston, West Virginia 25317
(304) 348-0238

WISCONSIN

Driver Record File
Department of Transportation
P.O. Box 7918
Madison, Wisconsin 53707-7918
(608) 266-2360

WYOMING

Criminal Identification Division
Boyd Building
Cheyenne, Wyoming 82002

NDR

National Driver Register
Room 5117, NHTSA
400 7th Street SW
Washington, D.C. 20509

DISTRICT OF COLUMBIA

District of Columbia Department
of Transportation
Bureau of Motor Vehicles Services
301 C Street NW
Washington, D.C. 20001

30-640 O - 84 - 5

GUAM

Mr. Patrick Wolfe
Deputy Director, Revenue
and Taxation
Government of Guam
Agana, Guam 96910

PUERTO RICO

Mr. Jose A. Zayas-Berdecia
Director
Bureau of Motor Vehicles
P.O. Box 41243
Santurce, Puerto Rico 00940

Virgin Islands

(Does not participate in the
National Driver Register)

Senator EXON. Mr. Chairman, could I interrupt here for a couple of questions of the Secretary.

Senator HUMPHREY. Excuse me, Senator Exon. Let me state our policy. We will question the Secretary and then receive the statements from the other witnesses and question them as they appear.

Senator EXON. Mr. Secretary, I am puzzled by this information that drugs are down while drinking is up. Does your study show an interrelation there? Are you indicating, for example, that they have given up some of the drugs, marihuana and other things, and are using beer or liquor as a substitute? Is that what you are indicating?

Mr. JOHNS. I do not have scientific data to substantiate that, but I believe your inference matches mine.

As I went around talking to troops in all the services last year they would tell me, the junior people, that you are closing off the drug of marihuana and they have accepted the fact that this is not a short-term thing, they feel it is going to be in the future, and they have turned to their beverage of choice which is beer.

I believe that is a reasonable assumption. As I say, I cannot substantiate that, but I think we have unwittingly done that.

Senator EXON. Are the difficulties that we are having with more beer and liquor drinking true of both enlisted and officer personnel?

Mr. JOHNS. Yes, it is. Particularly junior officers show an increased consumption of beer, too, across the board. We don't know what is causing this. I think a lot of it is the advertising is getting very good now. You can only advertise the beer at sporting events, and so forth, and it is having an effect.

Senator EXON. Is there a difference in the percentage of increased use of alcoholic beverages between enlisted men and officer personnel or is it about the same?

Mr. JOHNS. More for the junior enlisted.

Senator EXON. More for junior enlisted than for officers?

Mr. JOHNS. Yes. But there was also an increase in officers.

Senator EXON. Can you give me the difference? I haven't looked at the chart.

Mr. JOHNS. Yes, sir.

Senator EXON. Where is that in the booklet?

Mr. JOHNS. This is only for 1982. You would have to have 1980 to compare them. I do not have it to compare 1980 and 1982. I can only give you the absolute figures.

What I can say, for example, for E–1 and E–5 that those who average drinking eight or more beers a day at least three times a week, it was up from 8 to 12 percent, a 50-percent increase of eight or more drinks on an average drinking day.

Senator EXON. And what are the figures for officer personnel?

Mr. JOHNS. I do not recall those figures.

Senator EXON. You don't have that?

Mr. JOHNS. What we will have to do is go back and get the 1980 survey and 1982 survey. We will gladly provide that for you.

Senator EXON. One last question, Mr. Chairman.

Are there psychological reasons for this? Is it because they have time on their hands and they are not occupied otherwise? I suppose for the most part these junior enlisted ranks are single males.

Is this problem both in our male and female enlisted personnel? Is there a breakdown there?

Mr. JOHNS. Yes, sir. I can't give you statistics, but demographically the single male living in the barracks drinks more than the married, the female. So, in the services that are more heavily weighted with those demographics makeups you will find a heavier consumption, that is true.

I do have the comparative figures here. For junior officers there was, for example, total drinking and diminishment of work performance which because of alcohol use went up from 17 to 22 percent.

For single officers it went up from 12 percent to 19 percent which is about the same as the junior enlisted.

Senior officers, what we do have across the board, the senior and noncommissioned officers are the only ones that showed a very slight increase, 19 to 21 percent.

I should correct it to say for the junior enlisted and all officer grades there was a significant increase in impairment on duty because of alcohol use.

Senator EXON. Thank you very much.

Thank you, Mr. Chairman.

Senator HUMPHREY. Senator Jepsen?

Senator JEPSEN. First of all, Dr. Johns, will the Deputy please furnish copies of those charts that you do have for the record?

Mr. JOHNS. Yes, sir.

[The charts follow:]

1982 PREVALENCE OF NONMEDICAL ALCOHOL AND DRUG USE IN THE PAST 30 DAYS AMONG MILITARY AND CIVILIAN MEN AGED 18 TO 25

	Military	Civilians
Drug:		
Alcohol	85.6	75.7
Marihuana	25.1	34.7
LSD/hallucinogens	3.8	2.4
Cocaine	4.6	9.4
Stimulants	6.9	4.9
Tranquilizers	1.7	1.7
	.7	0

RESULTS OF DODD'S SENIORS SURVEY OF USE OF MARIHUANA, ALCOHOL, AND CIGARETTES

[In percent]

	DODD'S	Stateside
Marihuana:		
Use ever	58	59
Use in last 30 days	27	29
Daily use	4	6
Alcohol:		
Use ever	96	93
Use in last 30 days	79	70
Daily use	8	6
Cigarettes:		
Use ever	76	70
Use in last 30 days	36	30
Daily use	26	21

Senator JEPSEN. On your prepared remarks you discuss the testing techniques, laboratory versus the portable. You indicate that sometimes urine tests may indicate positive with a portable device, but negative by lab confirmation. Under current DOD policy such samples must be considered negatively.

Is there presently any plan to begin using only portable equipment to support disciplinary and military action?

Mr. JOHNS. No, sir, we will never do that because they are not reliable enough, they are not scientifically reliable. They are more sensitive than the gas liquid chromatography that we now use to confirm, but the gas liquid chromatography is considered scientifically accurate and protects the rights of the individual.

What we are looking at and are using in some labs is a more sensitive confirmation procedure called mass spectometry. That can go down to a very low level of sensitivity. Where we cut off gas liquid chromatography 100 nanograms per milliliter, the mass spectometry can go down to 15 nanograms.

In that way we will have a higher percentage of confirmation of the screening device of the portable kit.

Senator JEPSEN. On page 5 of your testimony you refer to two conferences already had and a third conference being scheduled for mid-October to examine refinements in your standardizing testing procedures and to review the data on GLC confirmation.

Will you please furnish the subcommittee with a summary of this third conference?

Mr. JOHNS. Yes, sir.

Senator JEPSEN. I am also interested that you have been doing a mass media campaign with radio and television spots.

I assume that is going to be part of your recommendation. I would like to know if you feel that they have had positive effects where you have used them?

Mr. JOHNS. I do. We do not have hard data to show, for example, the recruiting themes that switched from "The Army wants to join you" to "Be all you can be" and "You can do it in the Army," but it is, I believe, a consensus judgment that appeals to an entirely different kind of commitment to the military.

My own personal assessment of that is that that is a complete move and it is something that appeals to youth and lends itself to speeches at graduation, commencement exercises.

The answer is definitely yes.

Senator JEPSEN. It has an up-beat thrust to it and I think we have had enough of the other for the last couple of decades. It is about time we move in that direction, not only in the military.

So, I commend you and congratulate you. I will be very interested in working with you and I hope that you can develop some kind of follow up on the effectiveness of your programs to bring some sort of quasi, at least scientific support for your efforts.

I think that is very key as you come to my committee to suggest we authorize funds for development of television and radio spots to help change the life styles of our service people, I would suggest that some in the military probably will not think such spending necessary.

We are going to have to lead the way, but I am enthused with what you are doing.

I mentioned in my opening remarks casually that I think there is a relationship between the dramatic decrease in drug usage and the greatly increased morale of the troops.

Do you feel there is any evidence of that? Is that a logical assumption? Is it commonsense?

Mr. JOHNS. It is not only commonsense, but it is certainly validated by my own travels and discussions. There are a lot of people who were just tired of being in barracks where there was a lot of drug use.

I believe we have just about, with the use of sniff dogs, the court decisions to search and seize now within the barracks, with the urinalysis, I believe we have just about driven it off the military installations.

I am confident in making that assessment.

Senator JEPSEN. In the comments and exchange you just had with Senator Exon, it was pointed out that you went from a 12- to 19-percent increase, which is not quite 50 percent increase, but a 30-percent increase in the alcohol impaired performance of senior officers, with senior officers being in a command position and setting policy, is this alarming to you?

Has any particular thought been given to how you are going to handle it?

Mr. JOHNS. It is alarming. Let me say there could be different reasons for that.

One of the reasons may be our education, to make people more sensitive of how even hangovers can impair you on duty. We have tried to get this across through our educational programs that you don't have to be drunk on duty to be impaired, just the hangover can impair you.

It could be that they are honestly reporting, but I don't think we should take that as an excuse or an explanation for it.

What we are doing now in part of our plan is to look at all service schools to see what is being taught in the senior service colleges where most of our senior people go.

I am personally lecturing at the Air War College in February. I will lecture at the National War College and Industrial College in December and I believe that that is the way we have to put it across.

The whole National Defense University with both colleges had alcoholism among executives for their entire student body and wives of well-known executives, including former Senator Brewster and Mercedes McCambridge and others who present the sorts of things that cause people to become alcoholics.

I think we have to keep working at that. If we go with the breathalizers, I don't know how much we will have commanders requiring senior field grade officers to be tested with breathalizers.

I suspect we are going to run into a lot of resistance to that because of cultural inhibitions to question a senior officer and require him to do it.

Senator JEPSEN. Where do these statistics come from? Is this from surveys that are self-reporting?

Mr. JOHNS. Self-reporting surveys, one in 1980 and one in 1982, by the Research Triangle Institute from North Carolina.

Senator JEPSEN. If these are surveys in which people are honestly self-reporting, I guess, human nature being what it is, we might expect

this is probably the least that is going on. Being very candid, it probably is human nature to think that they are not impaired at all.

Mr. JOHNS. The research that has been done on reliability of surveys of this sort generally indicate that there is slight underreporting, but not much. When it is anonymous, for some reason people tend to tell it the way they see it.

So, research gives us pretty good confidence that this is accurate within a few percentage points.

Senator HUMPHREY. I want to congratulate you and your colleagues this morning on the progress that is being made. Obviously, there is more work to be done. That is a matter to which we are addressing ourselves today.

You have noted validly that the problem of alcohol and drug abuse in the military is part of the overall problem of the use in our society as a whole and there is no doubt about that.

At the same time I don't want to see the services, and I come at this from two directions, both as chairman of the Subcommittee on Alcoholism and also as chairman of the Subcommittee on Military Preparedness, I do not want to see you take too much shelter under that excuse or line of reasoning.

It is valid, but at the same time there is opportunity here, I think, inasmuch as the military is somewhat more controlled, as you yourself acknowledged, a more controlled society, there is more opportunity for improvement irrespective of what other parts of our society are doing.

You have promised a study in 2 or 3 months on an overall DOD plan to do what? What is the genesis of that study and what is its purpose?

Mr. JOHNS. When the Surgeon General's report came out in 1979 saying that we will make the most progress in health in the eighties by changing lifestyles, we took that to the military and said it makes sense and wrote a concept paper.

Secretary Weinberger, of course, needed no education since he had been at HEW and directed us to develop a strategic plan which would permit us to pull together isolated things we are doing now, develop a strategy for long term, to set specific goals and objectives to include a marketing strategy which I believe Senator Jepsen was suggesting is key to it, a marketing strategy that will get people's attention and that will elicit grassroots support and a lot of voluntarism with medical professionals giving clinics and giving education, and so forth.

We expect that if we can get the social system interacting parallel with peer pressure, get commitment among the families—you can't talk to a soldier about weight reduction and weight control unless you bring in his wife who does the cooking and purchasing of the food.

We have not done that systematically. We are going to do it systematically. Reducing cigarette smoking which is probably the biggest contributor to health cost in this Nation requires more than just telling people to quit smoking. It requires stress management, it requires exercise and nutrition. You don't handle those things as a unit.

That is the kind of strategy we will provide you.

Senator HUMPHREY. You are addressing health problems across the whole spectrum, not just drug and alcohol?

Mr. JOHNS. Yes. The evidence is you are more successful dealing with an undesirable behavior if you put it in a context of more positive connotation of general health rather than negatively.

Senator HUMPHREY. Didn't you say earlier in your testimony that you tried programs of advertising which a Rand report indicated was not effective?

What were you referring to there?

Mr. JOHNS. Our traditional information and educational programs have been based on providing factual information to individuals, trying to appeal to the rational part of the decisionmaking.

All the evidence shows that is not the way you change habits and behavior. You change it through the social system.

Senator HUMPHREY. The rule of rationality does not work in Washington.

Mr. JOHNS. Basically, we are shifting to a system approach where we make intervention with the individual, family, community, workplace level.

Senator HUMPHREY. Have you done any research on the correlation between tendency to abuse alcohol and drugs, for instance, and mental category?

Have you done anything to enable you to better screen accessions? Do you give people aptitude tests and qualification tests for those who want to become pilots or some other career?

Why should we not be screening out people who show some association with factors correlated with drug and alcohol abuse later on?

Mr. JOHNS. There are two ways you can do this.

First of all, educational level is correlated with it and as we have raised the educational level in the last couple of years, there is no question that we are bringing in fewer people with a predisposition to abuse drugs.

That does not apply so much to alcohol. Alcohol is no respecter of education or anything else except sex. The males drink more than the females.

Senator HUMPHREY. Let me interrupt you at that point.

You have not set out higher mental categories just to reduce drugs and alcohol?

Mr. JOHNS. No.

Senator HUMPHREY. Are we still taking a lower mental quota of mental category people just to be democratic?

Mr. JOHNS. No. Each of these individuals here has that as part of their function. I do not have it as manpower. I am sure each of the four services will tell you we do not do this.

Senator HUMPHREY. This significant increase in alcohol impairment among junior personnel is worrisome. Somehow to me it does not add up in that we have been getting better accessions over the last few years.

Do you think that this is a valid finding or are people being more frank in the 1982 survey versus 1980 in that category of questions or do you think this is really a significant increase?

Mr. JOHNS. I believe it is a real increase. As I said before, unfortunately the consumption of alcohol does not run along educational levels in the way illicit drugs do.

The college population drinks as much as other segments of our society.

Senator HUMPHREY. That is a real increase. That is quite a jump in a 2-year period. To what do you attribute that?

Mr. JOHNS. I mentioned at least for the junior people the consumption is almost all in the beer levels. I believe it is because they shifted from marihuana to beer as their beverage of choice.

The more senior people do not show they are drinking that much more and yet they are reporting more impairment. That may just come from a different definition in their own mind of what impairment is.

We have been hammering hard that if we are going to take the relative line on marihuana, which is a drug of choice of the junior enlisted people, then we should not be hypocrites on alcohol and we should understand that even hangovers are impairment.

Perhaps we are getting through to them. But that is just conjecture. I could not really tell you that that is the explanation for it.

Senator HUMPHREY. Your view is among enlisted personnel the increase simply is a switch from marihuana to alcohol?

Mr. JOHNS. Partly due to the success of the advertising of the beer. The beer commercials make my 11- and 12-year-olds hum "Miller Time." It is really catchy. I am not here to critique the beverage commercials, but I believe it is a real problem for us.

Senator HUMPHREY. What about availability? Is beer more available today than it was 3 or 4 years ago on base?

Mr. JOHNS. I don't believe so. It has always been so available that you have had beer dispensing machines since the early seventies, it is there for the taking.

Senator HUMPHREY. Since the early seventies it seems the whole beer machine mentality was an effort to get people at any cost to fill up the ranks. Since we don't have that problem any more, why don't we get rid of the beer machines?

Mr. JOHNS. The Marine Corps is the only service to prohibit beer in the barracks. They also aline their drinking age with the States in which the installations are located.

Yet the statistics show that the Marine Corps has the highest consumption per capita.

In my own command time, when you do not let it come into the barracks they go to the clubs. I just don't know how elastic the consumption is on that.

Your question is a good one and we are going to look at pricing. My new boss—or boss to be—has suggested that we do some experiments in Europe where we can control the environment to see if upping the price will cause some elasticity in the consumption.

Senator HUMPHREY. I am not a Pollyanna. I was in the service, myself. But I do recall that the easiest choice to have fun was to go to some place where you could get beer instead of gin. The easiest thing to do was to get a little high.

Mr. JOHNS. It still is.

Senator HUMPHREY. Maybe we ought to make it more difficult so that it is easier to have fun wholesomely. I am not a Pollyanna, but I think inasmuch as during the seventies we went further in the direction to make alcohol easier to obtain, it is time we move back away from that.

I would not predict any kind of magical cure, but I believe we should try it.

What is your thought on it?

Mr. JOHNS. I believe that is a valid point. Certainly if you make it more difficult to get, you would shift the focus for its use.

We found a study done by the Surgeon General of the Army in 1890 where they banned alcohol on military installations. On some it did not go down at all. VD went up, which meant they went off base to get their drinks.

I don't want to say that holds, that historical analogy, but when I talked to commanders when I was at Fort Campbell, Ky., last week, I said what would happen if we alined your drinking age with Kentucky's which is 21?

He said, "It is 18 miles to Clarksville, Tenn. You drive along that strip there, you see what would happen."

Senator HUMPHREY. I am not proposing prohibition. I think we ought to examine that extra increment that seems to have come into play during the seventies when we were desperate for anybody to come into the service.

I am just suggesting a focus on that increment of easier accessibility. I am not calling on prohibition because I know that won't work, knowing human nature. I do urge you to work on that.

Now, what about the anonymity in the self-reporting survey? Frankly speaking, how do you go about questioning a sailor or airman or soldier? It is hard for me to believe that an enlisted man, junior enlisted man, that it is possible for someone in that category to fill out such a survey with anonymity.

So, I wonder about the validity of the return?

Mr. JOHNS. First, we have a civilian contractor who goes to a military installation and selects people at random by serial number. They are put in a large room and they are handed out these questionnaires without any names. They do not put any names on them. They take those and they hand them in as they leave the room.

In questioning we had people question about whether or not they considered there was really any way of finding out who it is and we don't believe there is any problem with that.

Senator HUMPHREY. There is absolutely no tagging or identification of the form with one filling it out?

Mr. JOHNS. We do not even identify by installation. We aggregate the data.

Senator HUMPHREY. Thank you, Mr. Secretary.

We will be looking forward to seeing the study. It is a great idea and we wish you well.

If you wish to leave at this point, you may or if you wish to remain, you may.

In any case, we will go to the other witnesses.

We will proceed simply to receive the statements from each of the witnesses and then we will question them as a panel.

Our next witness is Maj. Gen. John H. Mitchell, Director of Human Resources Development Office, Deputy Chief of Staff for Personnel, Department of the Army.

STATEMENT OF MAJ. GEN. JOHN H. MITCHELL, DIRECTOR OF HUMAN RESOURCES DEVELOPMENT OFFICE, DEPUTY CHIEF OF STAFF FOR PERSONNEL, DEPARTMENT OF THE ARMY

General MITCHELL. Thank you, Mr. Chairman.

This is my second time before this committee on the same subject and I welcome the opportunity to return.

I will summarize my statement which has been submitted for the record.

The Army's goal remains essentially unchanged in this area and that is to free itself from the effects of alcohol and drug abuse. We are making a concerned effort to eliminate that abuse.

The 1982 DOD survey demonstrates that drug abuse has declined since 1980 and alcohol remains the number one substance of abuse. The Secretary of the Army and the Chief of Staff of the Army have clearly stated that abuse by leaders violates the special trust and confidence placed in them by the Army.

We have upgraded our drug abuse protection capability to include the expanded use of portable kits as a preliminary screening device for potential abusers. We require testing of personnel in sensitive duty positions such as aviation and military police and the personnel reliability programs and specialties.

Our separation procedures have been streamlined and a new policy, effective on the 1st of July of this year directs that separation action be initiated for selected categories of soldiers. That includes all officers and the top four grades of noncommissioned officers which would be identified as first-time abusers.

We are committed to the deglamourization of alcohol and a major effort is ongoing to reduce the problem of alcohol abuse. Our approach is to modify attitudes and behavior through education and prevention while offering positive alternatives to abuse.

At the same time, soldiers who choose to abuse will be held responsible for their actions. The Army has been and will continue to be committed to rehabilitate soldiers who demonstrate potential for useful service.

We are expanding rehabilitation facilities and increasing education efforts to insure that soldiers receive the best possible treatment.

If we are to maintain a quality force, and that is the type force we believe we have now, we must not only address the problems of individual soldiers, but the problems of the families.

In this regard we have initiated a program to incorporate family members into the alcohol and drug abuse prevention and treatment programs.

In summary, we are attempting to install in our soldiers the philosophy of mental and physical fitness as a means to a long and healthy life.

Our future success in the prevention of alcohol and drug abuse will be a positive factor in improving the conduct readiness of the U.S. Army.

That completes my summary statement, Mr. Chairman. I am available for questions.

[The prepared statement of General Mitchell follows:]

PREPARED STATEMENT BY MAJ. GEN. JOHN H. MITCHELL, DIRECTOR OF HUMAN RESOURCES DEVELOPMENT OFFICE, DEPUTY CHIEF OF STAFF FOR PERSONNEL, DEPARTMENT OF THE ARMY

Mr. Chairman and members of the Committee, I am Maj. Gen. John H. Mitchell, Director of Human Resources Development, Office of the Deputy Chief of Staff for Personnel, Department of the Army. I appreciate the opportunity to once again appear before this committee to discuss the Army's alcohol and drug abuse prevention and control program.

Dr. Johns has discussed the results of the recent DOD survey on alcohol and nonmedical drug abuse among the services. The survey results confirm the Army's perception of the prevalence of alcohol and drug abuse during the time frame that the survey was conducted. Specifically, data indicates drug abuse exhibited a downward trend from the 1980 DOD survey. This was substantiated by our own internal survey taken during the same period August 1982. Subsequent Army survey results for February 1983 show a continued decline from the August survey by an additional four percentage points. Although not yet available, we anticipate that the results of our August 1983 survey which was recently completed will reflect further decline in abuse. This indicates to us that our approach to addressing drug abuse is appropriate.

The Research Triangle Institute (RTI) survey has also reaffirmed our perception that alcohol remains the number one substance of abuse. While the prevalence of heavy drinking declined, the adverse effects of alcohol abuse showed a noticeable increase as did the prevalence of moderate drinking. The implied impact of work impairment and lost duty time on our combat readiness are of grave concern to leaders at all levels of the Army.

The last time I appeared before this committee I outlined the Army's philosophy about alcohol and drug abuse. Our goal is to free the Army of the effects of alcohol and drug abuse among our soldiers, civilian employees and family members.

Army policies on drug abuse emphasize a balance between discipline and rehabilitation. On August 17, 1982, the Secretary of the Army and the Chief of Staff of the Army clearly stated that abuse of drugs will not be tolerated and that abuse by leaders violates the special trust and confidence the Army has placed in them. Since May 1982, the Army has reinforced its position on drug abuse by increasing and upgrading drug abuse detection capabilities; we have expanded our use of portable test kits as a preliminary screening device, and encouraged their use in sensitive duty positions (e.g., Aviation, military police, and personnel reliability program). We have streamlined separation procedures, and mandated the initiation of separation actions for commissioned officers, warrant officers, and senior non-commissioned officers identified as drug abusers as well as those soldiers identified as second time drug abusers. While these latter policies do not mandate separation, they do focus attention on leaders and those soldiers who fail to comply with the Army standard. The decision to retain or separate is uniformly elevated to the respective discharge authority.

As alcohol is a legal, socially accepted substance, the Army policies on alcohol abuse focus on the deglamorization of excessive alcohol consumption, the individual's responsibility to conform to laws and regulations, and the promotion of responsible drinking. These policies include stricter standards within service clubs concerning "Happy Hour" sales, establishment of a work impairment standard of 0.05 percent blood alcohol content (BAC), use of breathalyzer machines to detect abuse on duty, and harsher Driving While Intoxicated measures. Many of these policies were not in effect at the time that the RTI survey was conducted and consequently their impact on reducing the adverse effects of alcohol presented to you today have not been measured. The Army has already implemented several of the measures which DOD is considering and we are currently reviewing the issue of aligning the drinking age on installations with respective state laws. Additionally, we are currently developing an alcohol prevention and control strategy for the next 18 months to 5 years. Scheduled to commence in November 1983, this strategy will orchestrate policy initiatives, media campaigns, education and prevention efforts to promote responsible decisions about the use of alcohol. The goal is to educate and prevent abuse without punishing the majority of personnel who drink responsibly.

While the Army is emphasizing the individual's responsibility to obey the laws and regulations, we continue to provide rehabilitation programs to those quality soldiers who have demonstrated potential. Rehabilitation remains a viable manpower conservation mechanism. In fiscal year 1982 we rehabilitated over 24,000

soldiers for a cost avoidance of approximately 169 million dollars. Our alcohol and drug abuse prevention and control program today is one that stresses quality. The program itself has been reorganized to meet the needs of the individual through a progressive rehabilitation system which provides treatment and education depending on the degree of abuse. Instructional programs for counselors have been refined to insure that our soldiers get the best possible treatment. Yet at the same time, we have pared down the manpower resources to what we consider today to be the most efficient and cost effective level.

Several months ago, the Army reaffirmed its commitment to provide for its family members. This declaration is based on the premise that our families have a direct impact on the retention and readiness of our force. If we are to create a Quality Force, we must not address the problems that affect the soldier, but also the problems of those that are a part of his/her life. In this regard, the Army has joined forces with the nation-wide movement of parents and teenagers, private industry, and other Federal Agencies in attacking drug and alcohol abuse among youth. Specifically, we have undertaken a series of initiatives within existing resources that recognize the problem of abuse among our family members. These include revising our existing training for counselors to address family and adolescent problems, publication of special guidance for commanders to use in organizing existing resources, and an ongoing Army-wide education campaign.

The delivery systems that we currently have in place are aimed at reducing the level of alcohol and drug abuse within the Army. However, we recognize that the soldier that we are recruiting today has less tendency to abuse than ever before. If we are to effect a reduction in abuse, we must focus our attention on preventive measures.

We have instituted education and awareness training for all soldiers within the Army. This method of delivery is being further refined and we will complete implementation into all of our service schools by the end of FY 84. Last year, I outlined various films that were being made for Army use to emphasize the incompatibility of drug and alcohol abuse with military service. The films are now in the final stages of editing and will be available to the field starting this calendar year.

We are attempting to instill in our soldiers a philosophy of mental and physical fitness as a way to a long and healthy life and as a way of increasing our combat readiness. Efforts to free the Army of the effects of substance abuse will be incorporated into a Total Wellness concept which integrates physical fitness, stress management, and the Army-Family partnership, and focuses on the individual, the work team, and the organization.

In conclusion, we are committed to reducing the effects of alcohol and drug abuse within the Army. Our policies and direction stress a balance between the individual's responsibility and providing rehabilitation, while at the same time we are focusing on preventing abuse. We anticipate that this approach will further the Army's goal of an Army of Excellence.

Thank you Mr. Chairman. I will be happy to answer your questions.

Senator HUMPHREY. Thank you, General Mitchell.

Our next witness is Rear Adm. Paul J. Mulloy, U.S. Navy, Director, Human Resources Management Division, Office of the Chief of Naval Operations.

STATEMENT OF REAR ADM. PAUL J. MULLOY, U.S. NAVY, DIRECTOR, HUMAN RESOURCE MANAGEMENT DIVISION, OFFICE OF THE CHIEF OF NAVAL OPERATIONS

Admiral MULLOY. Thank you, Mr. Chairman.

I would like to publicly thank you for the support the committee has been giving to us on the war on drugs and the alcohol effort.

The Navy's enthusiasm and awareness are up. They know you are behind us. They know we are serious on this business and support in the budget helps.

I have prepared a statement which has been introduced. If I may summarize some of the highlights of what we have done.

Marihuana abuse by junior people has gone down from 47 to 17 percent based on the results of the 1982 DOD worldwide survey. Our estimate is that right now we are running, based on laboratory confirmations, less than 10 percent positive on our urinalysis tests.

Our goal is to collect 1.8 million specimens a year. That is over 9.6 million tests a year. That means every sailor in the Navy, admiral to seaman, will average three specimens a year. He never knows when.

So, the people know we are serious. We believe it is working. Why? Our retention is up 9.5 percent. Our unit operation readiness is up 10 percent. Our personnel readiness is up 17 percent.

From a rate of 20 percent positive for 650,000 tests taken in 1982—in the 1983 fiscal year we have run over 1.2 million specimens—we are down to 7.6 percent on positives.

Reports from fleet commanders in chief attest to positive impact on morale, discipline, retention, and mission accomplishment. All reflect on the positive impact of our war on drugs and urinalysis testing.

Last year when I was here I showed you our draft policy directive. It is one comprehensive Navy directive for substance abuse. It was issued in November 1982. It tells exactly what the rules and programs are, the attitude and behavioral changes desired, and what we are doing about substance abuse. Navywide, our people seem to like it.

The task we set for ourselves was to achieve peer-accepting responsibility. We said we would win through enlightened leadership and peer responsibility. The peer change is taking hold. You can see it out there in the fleet.

Urinalysis is our most effective deterrent and detection device. That is really getting the attention of drug abusers.

We have changed our laboratory procedures which certainly improved overall performance. We went very heavily into standardization, quality improvement, quality control of personnel, testing of the lab personnel themselves, and bimonthly inspections of the laboratories.

We now have five laboratories to accommodate this load, plus a civilian laboratory. We are pleased with those improvements and they are steadily improving.

On our rehabilitation programs for substance abusers, we have a three-level approach. At the command level, programs to counter substance abuse are coordinated by substance abuse coordinators from 3,500 commands. These substance abuse coordinators have been trained to provide onboard expertise to assist the commanding officer. At the second level, you get 36 hours remedial education and training. We are also encouraging attendance by people who are in supervisory positions to increase their awareness.

Then we have a third level of treatment, up to 9 weeks of residency. They are all working well and the number of people going through has increased.

For example, in 1982 residential throughout was 5,483. In 1983 we are expecting 5,600.

With the new emphasis we are putting on supervisors going to training, we may eventually have up to 65,000 people going through our second level. We think that is a real key and increases awareness.

Alcohol is still the No. 1 substance as Dr. Johns has indicated. We, too, in Navy know that. Alcohol is associated with several Navy traditions, but it has never been an acceptable tradition to abuse the substance.

In August, CNO, Admiral Watkins had his staff together. He is starting a real campaign against alcohol abuse even though we have an effective program to begin with. We are looking for alternatives and methods of changing attitudes, recreational alternatives, such as all-night gyms, elimination of nuisance fees, and expanding facilities.

Some of these have already been done because we put this policy out over a year ago. Some bases are running all-night movies.

Instead of reducing the price of the drinks, reduce the price of the steaks, get the families involved, put more resources into it, upgrade recreation facilities.

The CNO has stated in the next budget he wants greater increase in the recreational facilities. For example, keep the gyms open when the bars and clubs are open. It works. An increase in appropriated support would help.

We are evaluating use of breathalizers. We are going to commence a 6-month pilot program to judge the impact of what the Secretary of Defense has indicated, with regard to 0.05 percent blood alcohol content. We want to see what this does to morale and readiness because alcohol is a legal substance.

We don't want to signal that we don't trust our people. I think the initiative with the greatest potential downstream, that I get excited over is quality of life through fitness and healthy lifestyles, and stress reduction. Get high on yourself, as Senator Jepsen said.

With the cooperation of Dr. Coop, the Surgeon General of the United States, we have developed a program starting this month where our people are going to have to meet fitness tests.

In conjunction with that we are looking at the wellness approach to change the attitudes on substance abuse or use stress management, smoking cessation, and so forth. Start thinking "high" on yourself. Get the families involved through the family service centers which you helped establish, and they are really helping.

At the commands we are looking at getting our people together three times a week, for education and training in order to improve fitness, change attitudes, and behavior.

The original 1980 DOD survey statistics were shocking. Illicit drug use is something we must combat. That is the direction we have gone since 1981 and will continue to go. We are waging a war on drugs.

The goals are the same, combat readiness and retention. We are proud of what we are doing. We still have a way to go, but we are sure we are going in the right direction, and we thank you for your help.

[The prepared statement of Admiral Mulloy follows:]

PREPARED STATEMENT OF REAR ADM. PAUL J. MULLOY, U.S. NAVY, DIRECTOR, HUMAN RESOURCE MANAGEMENT DIVISION, OFFICE OF THE CHIEF OF NAVAL OPERATIONS

Mr. Chairman and Members of the Committee: I am Rear Admiral Paul J. Mulloy, Director, Human Resource Management Division on the staff of the Chief of Naval Operations. I welcome this opportunity to appear before you

today to update you on the positive impact Navy's aggressive efforts in waging its war on drugs has had and explain the major campaign we have embarked on to counter alcohol abuse. The latter effort includes strong emphasis on installing awareness, education, and deterrence programs at every Navy installation to combat drunk and drugged driving, working in cooperation with surrounding civilian communities, as well as improving and expanding our treatment capability.

I would like to take this opportunity to publicly thank each member of the committee on behalf of the Chief of Naval Operations, for the tremendous support you have given us in meeting the problem of substance abuse head-on. On the occasions when I have had the honor of personally speaking with Members of the Senate, I have always come away impressed by the enthusiastic backing for our policies and programs. This firm support is absolutely vital to the success of our programs in combating the menace substance abuse poses to national security and readiness.

As you know, our war against drugs has been fought on several fronts using various tools and weaponry. The twin bases of enlightened leadership and peer responsibility are indeed taking hold. From our ten point program, let me start with the area of detection and deterrence. We have employed drug detection dog teams, expanded law enforcement efforts, and expanded the single-most effective element, our urinalysis drug testing program to process 1.8M specimens annually, which means over 9M tests per year based on the fact that we test for six different classes of drugs.

The Navy presently has 188 active drug detector dog teams and during the first half of 1983, these teams completed over 52,000 searches which were conducted at base entry points, onboard ships, in barracks, warehouses, storage buildings and aircraft. The drug dog teams have proven themselves an effective means of sniffing out illegal drugs and, in fact, their very presence is a deterrent.

During the calendar year ending in August 1983, the Naval Investigative Service (NIS) initiated 6,136 narcotic investigations. The NIS continues to conduct narcotic suppression operations in foreign ports visited by Navy ships during deployments. These operations are conducted in concert with local authorities following liaison with the appropriate U.S. Embassy. These operations are aimed at local foreign national drug dealers operating in areas frequented by American sailors and Marines ashore. Six major operations were completed as of August 1983, with more planned. Stateside, NIS works closely with civilian law enforcement agencies conducting narcotics interdiction operations. These operations normally involve undercover operatives purchasing illicit substances from civilian and/or military personnel trafficking in drugs. One of these operations, ongoing in the San Diego, California area and being conducted jointly with local law enforcement agencies and the Drug Enforcement Agency (DEA), has met with significant success. The operation began in January 1982 and as of August 1983 has led to the arrests of 495 drug traffickers and the recovery of $378,811 worth of illegal drugs. The results are impressive.

Our expanded urinalysis drug testing program consists of five Navy laboratories (Jacksonville, Portsmouth, Great Lakes, San Diego and Oakland), a civilian contract lab to assist in confirming portable kit results using the state of the art gas chromatography/mass spectrometry and over 500 portable urinalysis kits. Urinalysis has become the major means of identification, out pacing standard low enforcement methods and self-referrals. We are constantly improving the whole system to insure its reliability, credibility and effectiveness. We focus flag-level attention on this program to continually assess and improve our procedures and control. There are numerous built-in checks and balances in our urinalysis drug testing program that have been instituted and improved upon in the past year and a half. For example we perform a screening test and confirmatory test, monitor procedures and output through a rigorous quality control program, and most importantly rely on Commanding Officer's judgment in weighing all factors in a case, before substantiating and prosecuting drug abuse. We have had some lab mistakes and will probably never completely eliminate them. But in every case we rectify if there is any doubt, and resolve in favor of the individual. In 11½ months of fiscal year 1983, since the problems at our Oakland Laboratory were corrected we have had an error rate of 0.002 percent. But because of the potentially serious consequences of a determination to effect disciplinary or discharge action we are constantly working to improve even that low rate and ensure each Navy individual suspected of drug abuse gets a fair and just hearing, and due process. In resolving cases, we "err" in favor of the

individual rather than make an unjust determination. We have established our laboratory confirmation levels such that we know some guilty people are getting by, but it keeps the margin of error away from the innocent. Whenever errors have been made, the Navy has and will continue to take the initiative to correct those errors. The Navy urinalysis drug testing program has weathered negative criticism, has proved to be scientifically and medically reliable, and has stood up in court as solid evidence. We have been particularly sensitive to the rights and sensibilities of the individual while aggressively pursuing our goal of a drug-free Navy.

On the especially important education and training portion of our 10 point program we are continuing our internal "media-blitz" which is aimed at providing hard facts on the dangers of drug and alcohol abuse to every Navy member. We quickly route to all our officer and enlisted accession programs necessary educational materials to be sure they get first-hand the facts to counter the street knowledge they bring with them into the Navy. To enhance the flow of information and increase awareness, Navy is also in the process of training petty officers for the collateral duty of providing resident expertise at the command-level. These individuals will be able to deliver command education programs, act as a point of contact for self-referral for treatment, and provide counseling and aftercare follow-up. This is a major undertaking designed for implementation Navy-wide. Our highly successful Navy Alcohol Safety Action Program and Navy Drug Safety Action Program, modeled after the Department of Transportation's Alcohol Safety Action Program, expect to reach 50,000 Navy members in fiscal year 1983.

Our treatment and rehabilitation policies have been modified to insure that those who need help are given assistance at the most appropriate level. We have instituted a three-level approach to rehabilitation and treatment that begins with command-level programs, progresses to counseling and assistance programs, and at the tertiary level, residential rehabilitation programs. Primary emphasis is on direct attention by appropriate remedial administrative action (if warranted) and/or corrective re-education through our drug and alcohol safety action programs. This approach continues to prove the most effective. It engages the problem right at the ship or squadron level where shipmate leadership and peer responsibility can be best applied. We are streamlining our programs for efficiency and to improve quality of life for our people. There are lower cost ways to rehabilitate members than residential treatment; therefore, it is restricted to only those individuals from the Commanding Officers judge to have good potential for further useful service. We are convinced that most repeat offenders are disobedient individuals who refuse to adapt to the rigors and tested standards of our naval service. They are not addicted to drugs in the commonly accepted meaning of the term. They are maladaptors who disrupt the close-knit trust, confidence and combat effectiveness of their shipmates. Even so, the traditional helping hand is still there and always will be. It is a time honored Navy tradition that shipmates take care of shipmates.

The effectiveness of our programs is monitored by various assessment and evaluation techniques which include surveys and reports. We have taken positive steps to enhance our data gathering capabilities and keep pace with our dynamic and comprehensive programs. Reports from commanders in the fleet are enthusiastic about Navy policies and the progress we have achieved thus far. The results of the recent DOD Worldwide Survey on Alcohol and Non-Medical Drug Use reflect a dramatic reduction in the levels of drug abuse and confirm our own estimations of the seriousness of the alcohol abuse problem. For example, any drug use by our junior enlisted (E1–E5), during the 30-day period prior to data collection for the DOD survey, dropped from 48 percent in 1980 to 21 percent in 1982. Marijuana use, the most highly used illegal drug, dropped from 47 percent in 1980 to 17 percent in 1982, for the same group. This marked reduction was also reflected in our own random urinalysis surveys conducted in San Diego and Norfolk. The downward trend continues based upon a review of urinalysis tests conducted at Navy Drug Screening Laboratories and the percent screening positive, which represents a worst case as not all samples then confirm positive.

We are well aware that alcohol is still the number one substance of abuse. Since our crackdown on drugs, the noticeable shift to alcohol became the impetus for a major campaign ordered by the CNO, Admiral Watkins, to counter alcohol abuse. Admiral Watkins has been briefed on the problem and we are formulating a new strategy and program to implement a strong set of alternatives to alcohol abuse. He provided clear emphasis on moving out smartly but with a

strong helping and compassionate hand to our shipmates and for all leaders throughout the chain of command to set the example. Our approach will be to focus on three areas:

Awareness.

Alternatives.

Actions.

Specific initiatives included in this campaign are:

A course setting policy message from the Chief of Naval Operations.

Expansion of current awareness and preventive education programs including specialized training for club managers and staff.

Upgrade of recreational and fitness programs.

Institution of club and recreational activities that deglamorize and provide alternatives to alcohol consumption.

Evaluate increased use of breath analysis equipment.

The Navy's new Health and Physical Readiness Program—Fitness for Life—is designed to be an integral part of our efforts to counter substance abuse. Our human resources, the men and women in blue, are our most valuable asset. Fitness for life is a comprehensive program designed to achieve a healthier, more productive lifestyle by emphasizing regular exercise, proper nutrition, weight control, substance abuse prevention and control, high blood pressure control, and stress management. We have developed our Health and Physical Readiness Program with the able assistance of the President's Council on Physical Fitness, the National Institutes of Health, and the University of Arizona among others. On October 1, 1983, Navy's commitment to improving quality of life through a balanced program of Health and Physical Readiness and Substance Abuse Prevention Programs was renewed.

We are confident what we're doing is the right thing for national security in improving the combat readiness, safety and fitness of our personnel. With your continuing support nnd growing public awareness and resolve, I know we will enjoy the same success in our campaign to counter alcohol abuse as we have in our war on drugs. Thank you for permitting me this opportunity to share this progress report with you and to assure you of my commitment and enthusiasm in helping our shipmates win.

Senator HUMPHREY. Thank you, Admiral.

Next we will hear from Maj. Gen. Robert C. Oaks, U.S. Air Force, Director of Personnel Plans.

STATEMENT OF MAJ. GEN. ROBERT C. OAKS, DIRECTOR OF PERSONNEL PLANS, U.S. AIR FORCE

General OAKS. Thank you, Mr. Chairman.

We appreciate the support that the committee members have given us in our efforts to combat drug and alcohol abuse.

Since our 1982 testimony we have continued our pressure on reducing the negative impact of substance abuse in the service and especially on readiness.

Our comprehensive education, identification, rehabilitation, and punitive efforts have been expanded to make substance abuse less attractive to our members.

In terms of the current situation we talked about at some length, we have that same situation of decrease drug participation and increased alcohol abuse. This underscores the need for continued emphasis to stimulate early identification of the alcohol abuser.

We realize the mission degradation that can result from substance abuse and our commanders are encouraged to keep a careful eye for signs of substance abuse and take action when it occurs.

We emphasize rehabilitation and that also supports our readiness posture. These efforts have been key to early identification and rehabilitation reserved for those drug and alcohol abusers who clearly demonstrate potenial for successful continued service.

The foundation of our personnel quality force is our personnel reliability program. This program is a necessary safeguard to assure our members who perform duties with any component of nuclear weayons are free from substance abuse. This is at all levels of command and provides a systematic method of removing members who are identified as substance abusers.

We have no indication that substance abuse is limiting the ability of any unit to accomplish the assigned mission. The ability to use urinalysis coupled with the ability of commanders to take action to discharge members based on test results has caused urinalysis to become the major deterrent against drug use.

Our commanders use these means to identify, and discipline, and rehabilitate drug abusers.

With regard to alcohol abuse, we have encouraged our commanders to conduct stronger prevention, education, and rehabilitation programs and to separate those abusers who will not or cannot be rehabilitated.

We are expanding our alcohol awareness education programs to encourage more aggressive supervisory identification of abusers, we have strengthened family assistance and support services to alleviate alcohol problems within the family.

We have strengthened our residential treatment programs for those abusers who become alcohol impaired, we have conducted alcohol training seminars for senior officers, and conducted family and substance abuse workshops for health professionals assigned to dependent schools overseas.

We have intensified our emphasis against DWI by cracking down on offenders, as Dr. Johns indicated.

Following the lead of the 1982 DOD DWI conference, we have launched a comprehensive Air Force-wide anti-DWI program. The goals of our program are to reduce DWI injuries and deaths among Air Force personnel by 10 percent per year for the next 5 years.

To do this we expect to change the knowledge, attitudes, and behavior which affect drunk driving. This will, of course, put emphasis on those installation DWI programs that we have discussed.

In summary, the combination of the technical ability to detect marihuana through urinalysis and the ability to use the results in disciplinary proceedings has contributed to a major decline in drug abuse.

With respect to alcohol abuse, we will continue to develop news ways and use the old ways we have already discovered to meet this challenge.

We will continue to use all resources available to provide our men, women, and families freedom from the serious effects of alcohol and drug abuse.

These efforts will insure that we continue to hold to the highest standards of combat readiness in the Air Force.

[The prepared statement of General Oaks follows:]

PREPARED STATEMENT OF MAJ. GEN. ROBERT C. OAKS, DIRECTOR OF PERSONNEL PLANS, U.S. AIR FORCE

Mr. Chairman and members of the committee: I appreciate the opportunity to appear before this committee to discuss the efforts made by the United States Air Force to combat the effects of drug and alcohol abuse. Since our 1982 testimony before this committee, we have continued our steady, tough, nononsense approach to combat the negative impact of substance abuse. We have refined the comprehensive drug and alcohol abuse control programs we began more

than eleven years ago to meet the needs of a changing Air Force environment. Throughout this period the central theme of these programs has not changed: drug and alcohol abuse is incompatible with the Air Force mission and we hold commanders responsible for preventing it. We continue to expect commanders to initiate swift, firm disciplinary action when drug abuse occurs, to provide both discipline and rehabilitation to those drug abusers who possess the potential for further useful service and to separate those who cannot or will not maintain standards.

Senior leadership interest, support and guidance for the drug and alcohol abuse programs have been a constant theme in the Air Force and the key to our success. We hold unit commanders responsible for program implementation and believe that deterrence of abuse can succeed only through strong leadership and individual commander involvement and commitment. Our commanders fully understand that aggressive pursuit of drug and alcohol abuse problems is an integral part of their responsibility.

To enhance the ability of our senior leaders to reduce alcohol abuse we offer an annual alcohol orientation program to newly promoted Brigadier Generals and senior staff officers. This program was designed to provide senior leaders with an experiential orientation regarding such topics as the dynamics of alcohol addiction, techniques for intervention and treatment models.

Our comprehensive prevention and education program elements have greatly contributed to lowered drug abuse levels. Our first means of preventing drug and alcohol abuse is to ensure that we do not access new members with abuse histories. Any use of LSD, narcotics, or dangerous drugs, or a conviction of drug possession or trafficking (including marijuana), or current unarrested alcoholism are disqualifying for enlistment or commissioning. Preservice use of marihuana alone is not disqualifying, although applicants for Personnel Reliability Program positions must not have used it within six months. Before enlistment, all applicants must acknowledge in writing their understanding of Air Force standards. Accession policy toward drug and alcohol use helps ensure we do not induct drug or alcohol dependent individuals.

Our efforts to maintain a drug-free force continue well beyond accession. Beginning with accession training programs, including Basic Military Training School, Reserve Officer Training Corps, Air Force Academy, Officer Training School and our direct commissioning programs, each member attends a Drug/Alcohol Education (DAE) program. Following this training, all members receive a minimum of two hours DAE within 60 days of their arrival at a new duty station. While education at a new duty station continues throughout a member's career, more specific DAE information is integrated into each of our three levels of officer and four enlisted professional military education programs. In addition, members involved in a drug or alcohol related incident attend an eight-hour awareness seminar which is both educational and rehabilitative.

Other Air Force programs and initiatives contributing to our prevention and education effort include: the publication of drug and alcohol abuse information in internal media, especially base newspapers; the Air Force-wide distribution of literature, pamphlets, etc. produced by the National Institute on Drug Abuse and National Institute on Alcohol and Alcoholism; distribution of commercially produced literature and films; and special presentations by our drug/alcohol abuse control specialists to wives' clubs, civic organizations and community schools.

Our current benchmark of drug and alcohol abuse prevalence levels is the 1982 DOD survey conducted by the Research Triangle Institute. The survey reported that our drug abuse rates dramatically declined; fewer of our people are abusing drugs now and then at any time in the recent past For example: the survey reported that diminished work performance for any drug use was reduced from 9 percent to 7 percent and that the total marijuana/hashish use (during past 30 days) declined from 14 percent to 9.6 percent, to include a substantial decrease in marihuana use among Airmen E1–E5. This high risk group reported a decline in marihuana use from 20 percent to 15 percent. While these rates conclusively confirm the ongoing success of our efforts to reduce the impact of drug abuse, the prevalence of alcohol abuse among Air Force people increased. For example: the survey reported that diminished work performance increased from 20 percent to 28 percent and more personnel became "drunk without planning to." These are disturbing measures and underline the necessity to keep seeking solutions to the problem of alcohol abuse.

With regard to substance abuse and unit readiness the following is provided: senior leaders at all levels are attuned to the potential for mission degradation

that could result from substance abuse. As previously discussed, unit commanders are expected to keep a watchful eye for signs of such abuse and take swift corrective action when it occurs. To date we have no indication that an incident of substance abuse measurably degraded mission effectiveness or unit readiness. These facts give us no cause for comfort, but do underscore the effectiveness of our program. Our policy will continue to emphasize that substance abuse is incompatible with the Air Force mission, it will not be tolerated, and we will continue to hold commanders at all echelons responsible for preventing it.

The urine testing program has assumed a major role in the drug abuse control effort. The advent of marijuana testing, coupled with the ability of our commanders to take disciplinary action and to characterize discharges based on properly collected samples has caused urinalysis to become the major deterrent against drug abuse.

During September 1982 the DOD lab system was modified to permit the individual services to operate their own drug urinalysis laboratories. Under this scheme the Army and Air Force began operating a joint drug testing lab system on October 1, 1982, with the goal of providing rapid turnaround and accurate results to commanders. This modified system significantly strengthened our commanders' ability to deter drug abuse. It has provided for increased lab capacity to screen 100 percent of all urine samples for marijuana and it has enhanced the credibility and reliability of urinalysis results to support disciplinary actions and to characterize administrative discharges. With regard to the portable urinalysis equipment, these devices are presently on hold until the Army/Air Force lab system is stabilized, and laboratory growth and requirements are properly programed into our budget process.

To insure that the Drug Urinalysis Program retains its viability as a credible drug deterrent we have launched a special evaluation project to assess the program's effectiveness. Through this effort a special Inspector General, Functional Management Inspection Team is currently visiting Air Force installations worldwide to assess local quality control procedures for the urinalysis program. This team is also evaluating lab processing procedures, responsiveness to unit commander needs, and the quality of commander responses to urine samples reported to be positive for illegal drugs. We will use the results of this inspection to modify our drug testing programs.

With regard to alcohol abuse, we expect commanders to aggressively conduct strong prevention, education, and rehabilitation programs and to, normally, separate those abusers who will not or cannot remain rehabilitated. We have taken the following actions to reduce the negative impact of alcohol abuse upon work performance: initiated changes to accession screening to review DWI-related information; encouraged more aggressive commander and supervisor identification of alcohol abusers; cracked down on Driving-While-Intoxicated (DWI) offenders; strengthened the alcohol awareness education program; strengthened base level family assistance and support services offered by Drug/Alcohol Counselors, Chaplains and Medical Family Advocacy Officers; strengthened residential treatment programs for those members who become alcohol impaired; conducted an alcoholism and alcohol treatment training program for senior officers and conducted a special family violence and substance abuse workshop for health professionals assigned to Department of Defense Dependents School (DODDS) located in the Pacific, Atlantic, European and Mediterranean regions.

Further, we have intensified our emphasis against drunken driving. Although the Air Force has always placed emphasis on combating driving while intoxicated (DWI) incidents, and has had the lowest rates of DWI deaths and injuries among the services, our emphasis has previously been fragmented. Following the lead of the August 1982 DOD DWI Conference, the Air Staff convened a DWI Task Force in September, 1982. A 28 Dec 1982, Chief of Staff letter, set the tone for the Air Force DWI Program and a comprehensive USAF DWI Program Initiatives Guide established the guidelines for a sustained, five year effort to combat DWI injuries and deaths as well as institutionalize DWI emphasis Air Force-wide. The guide provided numerous initiatives in seven major areas for Air Staff, Major Command and base level staff agency assessment and follow-up action. A thousand copies of the guide were distributed to bases in January 1983 to establish grassroots management of our program. The goals of our program are: to reduce driving while intoxicated injuries and deaths among Air Force military personnel by 10 percent per year for the next five years; to change knowledge, attitudes and behavior which affect drunk driving; to establish consistent base DWI programs which incorporate local community efforts; and to provide ongoing internal information and assessment programs.

The initiatives outlined in the guide encompass internal public awareness, education, countermeasures, enforcement, adjudication, program management, and program evaluation efforts. The initiatives include recommendations for proposed articles for Air Force publications, film clips for "Air Force Now" film productions, increased enforcement efforts, involvement with the civilian community, changes in current regulations and education programs, and program evaluation approaches. These provide for a complete systems approach to accomplish the Air Fore DWI goals.

The Air Force Program already contains the elements that John V. Moulden, Research Psychologist of the National Highway Traffic Safety Administration (NHTSA), emphasized to be major requirements for a successful DWI program. He noted these special emphasis areas in a paper presented before "The International Symposium on Alcohol and Driving" in November 1982 and again before the National Council on Alcoholism (NCA) in April, 1983. Three of these necessary elements, "systems approach", "local community focus", and "citizen support" are the backbone of the Air Force program and are the reasons the program is receiving such strong support from all levels of command. Additionally, the initiatives promoted by the Air Force closely parallel the initiatives which were later printed in An Interim Report to the Nation from the Presidential Commission on Drunk Driving. Of the Commission's 52 major recommendations, 36 correspond or are supported by initiatives in the guide, eight are currently being staffed or implemented by OSD, and eight did not apply to the Air Force structure. The Honorable John Volpe, Chairman of the Presidential Commission on Drunk Driving, in an address before the March 1983 USAF Worldwide Safety Conference, lauded the Air Force DWI program: "We are grateful to the Air Force for its support, interest, and implementation of the work of the Commission . . . the Air Force, as I see it, is in an enviable position to implement its own guidelines and take a leadership role not at the base level but as members of the wider community where the base is located."

Our DWI program is progressing well and gaining momentum in the field as new, dynamic initiatives are being independently developed at major command and base levels. We have made the following progress in meeting our program goals. Our initiatives in public awareness, education, countermeasures and enforcement are changing the Air Force environment in relation to our second goal to the point that it is no longer acceptable to drink and drive. Regulations and educational programs throughout the Air Force are being revised to include DWI emphasis, accession standards are being revised to include a screen concerning alcohol incidents which will specifically ask for DWI-related information, Air Force clubs are implementing dramshop practices and offering rides home, and on and off base parties now include designated drivers. Enforcement and detection within the Air Force has also been increasing as we continue to improve our Security Police training and DWI detection methods. This was evidenced by the fact that, for the first half of fiscal year 1983, DWI became the most prevalent alcohol abuse control rehabilitation entry source—1281, or 32.4 percent of our 3,957 total entrants were due to DWI incidents.

We are excited about the progress we see concerning our third goal of establishing continuing, local programs. All major commands and bases have established local programs using the Initiatives Guide as basis for their program. In many cases the bases have interwoven their base programs with local community efforts. Furthermore, we're proud that some of our base personnel have been asked to sit on community and, in the cases of Alabama and Colorado, to take part in state DWI task forces.

We realize that such an extensive effort requires constant internal crossfeed and evaluation. Our fourth major goal covers these areas. So far this year, numerous articles have been written in base newspapers and other local media and numerous other articles have been published in our "TIG Brief," the Inspection General's publication and "Driver", our safety publication. Plans are progressing for utilization of public service announcements for our monthly "Air Force Now" commander's call films. Additionally, many commands have established DWI as a command Special Interest Item for Management Effectiveness Inspections and established DWI Prevention Program Awards.

While the general consensus from our major commands is that it's too early to assess the impact the program will have on our primary goal, the reduction of deaths and injuries, all commands are enthusiastically and positively supporting program goals.

In summary, the combination of the technical ability to detect marijuana use through urinalysis and the ability to use the results in disciplinary proceedings has contributed toward a major decline in drug abuse among Air Force people. With respect to alcohol abuse we will continue to develop innovative approaches to meet the challenge of this form of substance abuse. We will continue to use all the resources available to us to provide our men, women and families freedom from the serious effects of drug and alcohol abuse. Our goal is maximum deterrence of drug and alcohol abuse and swift, firm action when abuse occurs.

This concludes my prepared statement. I would be happy to answer any questions you may have.

Senator HUMPHREY. Thank you, General Oaks.

We will now hear from Brig. Gen. James M. Mead, U.S. Marine Corps, Director, Manpower Plans and Policy Division.

STATEMENT OF BRIG. GEN. JAMES M. MEAD, U.S. MARINE CORPS, DIRECTOR, MANPOWER PLANS AND POLICY DIVISION

General MEAD. Thank you, Mr. Chairman.

It is a great honor to appear before this important subcommittee. I might say it is a great honor to see Senator Jepsen again. The last time it was ashore in Lebanon. It is nice to see you again, sir.

The Marine Corps concern for the welfare of all marines is the basic underlying consideration behind our substance abuse policies. The Marine Corps strongly believes every marine is entitled to a drug-free environment and opportunities for full and productive professional and personal life.

Toward that end the Marine Corps has developed a multifaceted program to address substance abuse. The program includes education, identification, detection, discipline and return to duty or discharge, as appropriate.

The message being consistently sent to the field since February 1982 is that the Marine Corps will not tolerate substance abuse. A marine trafficking in illegal drugs, officers using or possessing illegal drugs or any marine unwilling to accept the Marine Corps position on this issue will be disciplined, discharged, as appropriate.

The numerous control programs strive to identify, treat or rehabilitate and return to full duty those marines who sincerely desire help with substance abuse.

By a strong position against illegal use of drugs, the Marine Corps has drastically reduced drug abuse in the corps and through numerous urinalysis tests have recorded steady success in this area to the present when all indicators reflect a usage rate drop from 25 to 10 percent in less than a year.

The corps is very proud of this success and will maintain pressure in this area until drug use is eradicated.

On the other hand, sir, success in control of alcohol abuse is more difficult to achieve and measure. The Marine Corps is seeking to find a delicate balance between protection of individual rights to responsibly consume alcohol and means to identify and correct abuse of alcohol.

We believe this area requires great care in designing and implementing appropriate policies that truly correct problems and do not penalize those marines who drink legally and responsibly.

During this fiscal year 1,120 marines received formal rehabilitation and an additional 1,183 marines received some alcohol control assist-

ance at the command level. This represents an increase of 28 percent in help from last year.

The corps is adopting this issue as a challenge and like drug abuse will find a way to control this area.

I will be happy to answer any questions, sir.

[The prepared statement of General Mead follows:]

PREPARED STATEMENT OF BRIG. GEN. JAMES M. MEAD, U.S. MARINE CORPS, DIRECTOR, MANPOWER PLANS AND POLICY DIVISION

Mr. Chairman, members of the committee: I appreciate the opportunity to appear before this committee to discuss efforts made by the Marine Corps to combat drug and alcohol abuse.

On December 1, 1981, the Commandant of the Marine Corps announced a new drug policy, implemented February 1, 1982, that simply stated "the distribution, possession, or use of illegal drugs is not tolerated in the Marine Corps." With this position, the Marine Corps initiated its "War on Drugs" campaign that continues to this date. Over time, the concept of intolerance to drug use was extended to alcohol abuse, and numerous identification, detection, and correction treatment programs have been initiated in support of these positions.

The Marine Corps is committed to the belief that all Marines are entitled to a drug-free environment, with professional assistance available for drug and alcohol abusers who sincerely desire to adopt a more productive professional and personal life-style. Success in this area is dependent on a total leadership effort by Marines at every level, who are charged with the adoption of an intolerance to all substance abuse and with an understanding of the debilitating effects of dependency.

The multifaceted programs which strive to achieve this goal have been developed over time and disseminated in numerous documents. The Marine Corps is currently completing a major project to consolidate and clarify these policies and concerns into a single substance abuse publication. This document should be ready for distribution by the end of this month.

Using trends and concerns identified in the biennial DOD worldwide drug and alcohol survey, the Marine Corps has initiated a biennial Marine Corps-wide survey conducted in between the years of DOD focus. The purpose of this off-year survey is to extract data from a much larger Marine Corps population using regional and functional separations, providing a capability to produce service-unique data trends and analysis; i.e., comparing substance abuse between specific occupational fields or unit types. An additional spin-off benefit of the off-year survey is the availability of current statistics on which to base time-sensitive policy decisions. The Marine Corps-wide 1983 survey was conducted during June 1983 among nearly 16,000 Marines. Initial raw input is being analyzed by the Marine Corps Operations Analysis Group at this time. While maintaining complete anonymity, performance information of those surveyed is being reviewed in order to provide a link between dependency/self-admitted substance abuse and operational readiness.

The DOD 1982 worldwide survey highlighted both the dramatic decrease in drug use and an increase in alcohol use/abuse in the Marine Corps. In the area of drug abuse, the study recorded a 48 percent decrease in drug use as compared with use recorded in a similar study conducted in 1980, and registered a current (January 1983) Marine Corps usage rate of 25 percent. While accurate for the time period covered (October 82 to January 83), the success of the Marine Corps' "War on Drugs" can be even more clearly documented with more current information available in drug presence detection rates of the urinalysis program which continuously measures detected usage and has shown a steady rate decrease from 19.7 percent to 4.3 percent (August 83 rate) in less than a year. While recognizing limitations of the detection rates in assessing total use, this drastic decrease clearly reflects additional success in drug abuse abatement not measured in the 1982 study. Although we expect detection rates to rise in the next few months, the increase will result from improved urinalysis confirmation testing equipment being installed at DOD-certified screening laboratories at this time and not from a reversal of abuse patterns.

The urinalysis program has been the keystone to success in the Marine Corps' "War on Drugs," as it is the primary source of detection and deterrence. In light of the critical need to maintain reliability and faith in this program, the Marine

Corps has exerted considerable effort to establish an equitable system to correct administrative and/or disciplinary actions which now must be redressed as a result of the Oakland urinalysis invalidations. As a result of procedural errors found at Naval Drug Screening Laboratory Oakland, California, some positive urinalysis results are being invalidated. Our position in this issue is that the established quality control review process works, lending credibility instead of doubt to the urinalysis screening process. On September 15, 1983, the Marine Corps began implementation of a corrective plan for Marines involved in the Oakland invalidation. Because of limited Marine Corps impact, all corrective action should be completed in the near future.

While the Marine Corps is proud of its success in diminishing drug abuse, we are fully aware that the primary motivation for success has been threat of detection through urinalysis. Unfortunately, this extrinsic, short-term concept is necessary until long-term intrinsic behavior changes can be established through education and increased awareness.

Although tremendous strides have been taken to control drug abuse, alcohol abuse and admitted alcoholism have increased, an increase which was predictable with improved awareness, education, and detection. It is likely that much of this increase is attributable to better identification versus an actual increase in abuse/alcoholism. If this is true, continued success in identifying/treating Marine in this area will result in even higher identification rates in the future. Additionally, we suspect some real alcohol abuse/dependency increase may be due to transferrence of psychological or physical dependency from illegal drug use to this legal substance, in response to our strong drug policy.

The Marine Corps is taking a positive step to ascertain the scope of the alcohol abuse and dependency problems in order to develop appropriate policies and programs to deal with this issue. However, this issue is made more difficult because of the legality of alcohol consumption. Potential policies on this issue often cross over the clear delineation between eliminating abuse/treating dependency and protecting individuals' legal and moral rights to responsibly consume alcohol. Proposed policies and concepts clearly within legal parameters, such as those regarding intoxicated driving, drinking ages, etc., can and will be adhered to, while other control measures are more subjective and must be carefully considered under the auspices of safety and welfare concerns. Additionally, intangible factors, such as "machoism" and the tendency to cover for alcoholics instead of helping them, need to be addressed. Education and training emphasis is on early identification and either correction or treatment before alcohol abuse or dependency progresses to the point of irreparable damage.

Numerous programs have been initiated to enhance substance abuse control, to include training projects, such as junior/senior orientation courses, pilot bartender training course, etc. Additionally, an automated reporting system is being designed to provide a more accurate and current picture of substance abuse.

Although management tools are not yet available to measure the degree of impact on readiness, the Marine Corps believes substance abuse/dependency to be a readiness and command issue, and as such considers identification, detection, education, and rehabilitation efforts as command responsibilities. An important element in these efforts is the reinforcement of the view that all Marines have a responsibility for the lives of their fellow Marines. The Marine Corps' goal is to maximize accession, training, and maintenance resource costs by retaining and returning cooperative Marines to full professional and personal productivity, or, on the other hand, expeditiously discharging those Marines unwilling to adhere to Marine Corps standards.

This concludes my prepared statement. I would be happy to answer any questions you may have.

Senator HUMPHREY. Thank you, General Mead.

Mr. Secretary, the DOD's position over the years is that there should be no uniform servicewide program on alcohol or drug abuse, that it is better to allow each service to develop its own plan.

Is that still the position of the DOD? Obviously it is.

Mr. JOHNS. In general. We do not like macromanagement. However, on certain issues such as the penalties for drunk driving the Secretary felt it should be uniform so that everyone in the Department of Defense—of course, if we wanted to aline drinking ages with the States

on the installations, that is something we can do. We don't like to macromanage.

Senator HUMPHREY. One of the advantages of letting the services design, to manage their own programs is there has been some element of cross fertilization, some learning from others.

Can you tell us about some of the things that you have learned from one service versus another than can be applied elsewhere?

Mr. JOHNS. Let us take the 0.05 impairment on duty. General Wickham decided this on his own. He decided on his own to implement the 0.05 impairment and the use of breathalizers and told his commanders to buy breathalizers.

We think that is a sound idea. We took that and now we are floating it to the other services for comment. If we decide that that is something that we will impose DOD-wide, we won't hesitate to do it.

The Secretary does not hesitate even if he gets a nonconcurrence or disagreement by the service.

Senator HUMPHREY. What about the mandatory three times a year urinalysis program of the Navy? Does that seem to have any promise of applicability to the other services and if not, why not?

Mr. JOHNS. They don't have a mandatory three times. They have enough capability to average three times per person. We do not believe in urinalysis quotas. We went through that in the seventies. We think this is dysfunctional. It creates a resentment among commanders. I don't believe we will ever go back to that.

Senator HUMPHREY. How does it work on a practical basis. You have a capability of three times per year per member.

How do you do this?

Admiral MULLOY. That is our target. The way it happens, Mr. Chairman, is already in 1983 we have done 1.2 million even while we were building our laboratory capability. The controlling valve is the CINC's for unit sweeps of the whole ship and it is all done within the law, of course.

When you start taking those numbers out of the force of 570,000 enlisted and 60,000 officers you can rapidly get into the 1.8 million specimens targeted in a hurry.

All the boots are done, all the recruits. All the officer accessions are done. That is automatic. That is an immediate 100,000 a year and all the officer input. The accessions are on a routine basis. Ships are on a random basis, when the commanding officer wants to do a particular part of the ship. It all adds up to that many a year. We have said we want it done.

Senator HUMPHREY. Who makes the decision about which units are going to be surveyed?

Admiral MULLOY. If a destroyer skipper wants to do a ship, he has to get permission from higher authority to do the whole ship. He has to get permission so that we don't have mass influx to the laboratory. Unit sweeps could be imposed down from the commander, but we have not seen that done.

The thing is, hopefully, an enlightened approach. Let us say, a skipper comes out of a place where there is a heavy drug element, for example, Thailand, he would probably want to take the check on his

ship to see what the state of the union is. He would want permission to do the whole ship, and that has happened.

Senator HUMPHREY. Mr. Secretary, since urinalysis is so effective, can we use that in screening applicants for enlistment?

Mr. JOHNS. Some services do. I believe the Navy and Marine Corps are using it and the Air Force and Army are not. We have asked for data on it to seek how effective it is. If we feel it is a good case in point, if we think it shows long-term benefits, we would probably pressure the other services to do it.

It would be the same way with total use of urinalysis. Let us say the Air Force says, "Well, we don't believe in urinalysis." Our next survey shows they are not making much progress and the other services are, you can rest assured the Secretary will have a prayer meeting with the Secretary of the Air Force and say we ought to revise.

Senator HUMPHREY. General Mead, how does this work in the Marine Corps with regard to screening applicants for enlistment if urinalysis indicates use of drugs, what does that mean with regard to the enlisted?

General MEAD. Sir, on our accessions within 96 hours they are tested. Prior to that when they are in a delayed entry pool they are told what will happen to them.

What we have found in the last year is 4 percent of the marines we have accessed have used a drug in the prior 30 days, which gives us an attitudinal look at that marine on an individual case as to how well he is doing in boot camp to see if there has been an adjustment. We then make the decision.

So, approximately 50 percent of those who are detected when they first come in are allowed to stay in the corps and be tested again when they hit their first command.

It is very successful for us.

Admiral MULLOY. Being up front makes a difference. They know ahead of time and they also know in the fleet, a random test could be done any day.

Senator HUMPHREY. What is the experience when the urinalysis is positive on initial screening? What is the experience with these people? Do they generally make it? What percentage makes it? Would it be better to screen them out altogether?

Admiral MULLOY. I would like to provide it for the record; that first screen is not punitive. Nothing goes in the record whatever, if the test results are positive for marihuana.

[The information follows:]

TESTING OF RECRUITS

During the first three quarters of fiscal year 1983, 114,320 recruits were tested within their first 48 hours of bootcamp. Of those samples provided by the recruits, 4,867 samples were positive for a drug (3,955 for THC) giving a percentage of 4.3 percent. Those members who are confirmed positive for any drug other than marihuana are discharged. If the member is positive for marihuana, he/she is counseled and retested in 30 days. If positive on the retest a recruit is usually separated. If negative on the retest, no service record entry is made and he/she continues with a normal Navy career. The careers of personnel with positive urinalysis results on the 48-hour test are not currently tracked.

In July 1983, a survey of 1721 "A" school students was conducted to ascertain the drug problem subsequent to recruit training but while still in the training

pipeline. This survey consisted of a 10 percent random urinalysis of "A" school students who were onboard for at least two weeks. 1428 of the surveyed individuals were at "A" school directly from bootcamp. The remaining 293 individuals were from the fleet. Those who came directly from bootcamp had 38 positive urine samples (37 for THC, 1 for cocaine) resulting in a percentage of 2.66 percent. The fleet personnel had 6 confirmed positives (all for THC) giving a percentage of 2.04 percent. Both are considered very low, favorable percentages.

Senator HUMPHREY. I am talking about the very first screen.

Admiral MULLOY. In boot camp, recruits are tested within 48 hours. If the first screen is positive for marihuana, he gets another chance.

Senator HUMPHREY. All the services are exceeding their enlisted quotas.

Do we need to take people, even though forewarned, nevertheless used drugs within the 30 days?

Admiral MULLOY. The option, of course, would be to do it at the Armed Forces entrance and examination stations. That has been looked at pretty carefully, I believe.

Senator HUMPHREY. Why don't you do that, Mr. Secretary?

Mr. JOHNS. We don't think that is the appropriate place to do it. There is a different philosophy about whether or not you can condemn a person who has used marihuana before he comes into the service which is generally a misdemeanor.

We do lose them if they have trafficked, if they have shown dependence, and so forth. It is a judgment that we ought to give them a try.

Now, what I believe, I am not sure of the answer to your question. I think the people who identify in that initial screening, that the vast majority of those turn out to be good marines and sailors. They get the word and they stay off. I would not want to weed those out.

Admiral MULLOY. If I was not clear on that, Mr. Chairman, let me add it is our experience if an individual is a poor performer, he will come up a second time and we will say let him go home, but he goes home not too badly. He is still a youngster and there is no record of adverse separation action.

Senator HUMPHREY. Since you are not having difficulty getting high quality recruits, why take some at the center who have been forewarned? I think you should think about that. Is that in the realm of your jurisdiction?

Mr. JOHNS. I could recommend that to the Secretary. I have not and I am not inclined to do it. That is one of those judgments that I would prefer to leave to the individual service Secretary.

Let us get a base of experience to see before we make a DOD-wide policy. The problem, Mr. Chairman, I believe is also that the future may change events.

Once you lock into a policy—you want some flexibility.

Senator HUMPHREY. General Mitchell, how does this Army breathalizer business work? Is he asked or required to take this test?

General MITCHELL. Yes, sir. We did run a year-long pilot of the use of certain breathalizer equipment and found that its principal use was in the driving while intoxicated situation. But it also had some halo effect on just general use of alcohol during duty hours.

We have since, as Dr. Johns pointed out, authorized major commanders to purchase breathalizers and consequently, I am not able to report to you precisely the number that are operating in the Army

today, but we estimate it to be somewhere in the neighborhood of 250 to 300.

The experience to date has been positive in the deterrent effect of the use of breath testers as is the deterrent effect of urinalysis, at least it dampens the enthusiasm for soldiers to use alcohol on duty.

Senator HUMPHREY. You are not answering my question. Perhaps I did not phrase it clearly enough.

If someone is stopped and is suspected of drunk driving, he gets the breathalizer test.

General MITCHELL. He does indeed.

Senator HUMPHREY. Under what other circumstances would someone be given that test?

General MITCHELL. Some commanders are using the breath machines randomly during duty hours in the workplace.

Senator HUMPHREY. Randomly? Must he have some reasonable belief that alcohol has been used or can he just say, "Give us a breath"?

General MITCHELL It depends on what he wants to use the evidence for. He must have probable cause if he is going to bring charges. We believe that the major use of the breath machines is in the deterrent effect and consequently when I say random, that is precisely what I mean.

It might be unit sweep late in the afternoon or in the morning.

Senator HUMPHREY. This is like the Navy urinalysis program, isn't it?

General MITCHELL. In that there is a sort of arbitrary sweeping of units, sir?

Senator HUMPHREY. Yes.

General MITCHELL. That is correct.

Senator HUMPHREY. Mr. Secretary, I believe you raised some concern about invasion of privacy—I have forgotten the phraseology you used—with respect to that kind of application of the breathalizer test that the Army is doing.

Why aren't the other services?

Mr. JOHNS. We are circulating that proposed policy now to the services for comment. I personally see no difference between doing random alcohol breathalizer tests and urinalysis if we are going to be less than hyprocrites on this.

Senator HUMPHREY. I agree.

Mr. JOHNS. On the other hand, when I talk to senior commanders I get a different reaction from some of them. They say it is different. I don't think it is different, but they do. They say the culture is such about alcohol that if you do that, you are going to have a very adverse impact on morale.

They may be right and it is a sad state of affairs in my opinion, that that be true. It just signals to the junior enlisted people who think marihuana is no worse than alcohol, that we are hypocrites. That is my personal view.

We may conclude that we may not want to impose on the services any mandatory use, encouraging aggressive use and then in our judgment traveling around, if I conclude one service is not serious about it, I will go to the Secretary and say knock their heads.

That is the way we generally handle it.

Senator HUMPHREY. Senator Jepsen?

Senator JEPSEN. Thank you, Mr. Chairman.

General Mitchell, on page 1 of your written testimony you indicate that the results of the 1982 survey are not available right now, but they will be.

I would respectfully ask that you make the results of that survey available to these subcommittees.

General MITCHELL. Indeed, sir.

Senator JEPSEN. Dr. Johns, I think it is important to have the record clearly reflect the present ability of the Department's urinalysis testing. I understand that there are seven drugs that cannot be detected. Is that correct?

Mr. JOHNS. We now test for seven. There are some new drugs, synthetic drugs, that have come on the market that we do not have testing for.

Generally, like LSD we do not test for that. I think that as new synthetic drugs come on the market it will just be a question of time until we develop a reagent or a technique for doing it.

Senator JEPSEN. Can you list the seven drugs now that can be detected?

Mr. JOHNS. Cannabis, opiates, amphetamines, downers, barbiturates, cocaine, and PCP. Those are in the most widespread use.

Senator JEPSEN. Admiral, of the 50,000 to 60,000 people you expect to go through the treatment phase of your substance abuse program, do you have an estimate of those who return to duty as productive sailors and officers as opposed to being ultimately discharged for substance abuse?

Admiral MULLOY. The 50,000 to 60,000 referred to those people who are going through, for education purposes in our Navy alcohol safety action or drug safety action programs, not necessarily treatment. I will have to get you the specific for the recidivism, and so forth. I will provide that for the record.

[The information follows:]

ENTERED INTO REHABILITATION

During fiscal year 1982, 910 Navy personnel entered drug rehabilitation of which 122 members who failed treatment were terminated from treatment and returned to their command for further disposition. The alcohol rehabilitation centers admitted 4,573 clients for treatment, of which 1,323 members who failed treatment were terminated and returned to their command for further disposition. Past studies have shown that 82.2 percent of the personnel age 26 and older who complete alcohol treatment are successful in completing their naval career. Studies have also indicated that only 7 percent of the personnel completing Navy Alcohol Safety Action Program education courses subsequently come to command attention as a result of further alcohol abuse.

Admiral MULLOY. The point I was making is that it was 65,000 senior people and junior who will be going through our education. Some of them will be ordered into it to help them, others are going to go because they need to go as supervisors to understand.

Senator JEPSEN. Are those who are not going to make it discharged?

Admiral MULLOY. There would have to be an incident. There would have to be something that occurs. If they flunk that course for some reason and are not responsive to it, is that what you are asking?

Senator JEPSEN. The treatment.

Admiral MULLOY. If an individual fails a rehabilitation program, he or she may be separated.

Senator JEPSEN. General Oaks, on page 6 you talk about efforts.

What are you doing about intoxication on duty? Have you ever thought about these random inspections in the workplace?

General OAKS. Yes, sir; commanders have that option to conduct breathalizers. It is not encouraged or pushed. It is a tool available to the commander if he sees he has a problem. In such a case the commander would be expected to take this institution. That is a key to why we would be reluctant to do it across the board.

A couple of statistics on success in the Air Force. In terms of alcohol and drug rehabilitation. Our first quarter 1983 data indicated that for alcohol 77 percent of our folks who have gone through rehabilitation have succeeded and stayed in the service, drugs 49 percent.

That is our success rate with respect to rehabilitation of folks who were identified as offenders and went into the rehabilitation program.

Senator JEPSEN. Thank you, Mr. Chairman.

I have some questions that I would like to submit and request that they be answered in writing by this panel.

I thank the panel.

General Mead, I might say I just about said I didn't recognize you with your full dress on. At the time, we did meet over there you were dressed for battle as was everybody else.

General MEAD. Yes, sir.

Senator JEPSEN. It turned out that it is a good thing they were.

I believe we did manage to get the hospital ship. I heard about that.

General MEAD. Yes, sir, I sure did.

Senator JEPSEN. A piece of equipment they needed in surgery they had on order, they told me it was going to take 18 months to get it. I think they got it in 48 hours.

General MEAD. It is amazing how that works, sir.

Senator JEPSEN. I am glad they have it now.

I don't have anything further, Mr. Chairman.

Senator HUMPHREY. I need only a few more minutes.

General Mead, if the Marine Corps is the most rigid with regard to the availability of beer or alcohol in general, why is it the Marines have the highest incidence of serious consequences from alcohol use?

General MEAD. First, Mr. Chairman, for the Marine Corps I think if we allowed it in the barracks, our rate would be higher than it is. We don't like the rate. I think it is a reflection, when you look at the other services, of the demography of the Marine Corps.

It is a very, very young service, a lot of 18- and 19-year-olds and, therefore, lacking in maturity. I think your incidence of use is a reflection of maturity, attitudinal, you know. We have an attitudinal problem and we have to work on it. It will be very difficult.

Senator HUMPHREY. General Oaks, did the survey focus on air cruise and missile launch cruise in any way?

I would think they would be the most critical personnel in terms of readiness of the Air Force. Is there no breakdown of how these problems afflict those groups?

General OAKS. No, sir, there was not any breakout in the survey that addressed those specific individuals. However, we feel we have a good handle on that. There has been minimum involvement of either alcohol or drug abuse by aircrews.

For example, for substance abuse in 1982 we had nine aircrew members that were taken off flight status permanently because of substance abuse. The intenseness and closeness of the organization where crew members are involved, causes them to be totally intolerant of one another's abuse.

There would be no reluctance to come forward and say, "John has a problem," because their lives are all directly involved in it.

With respect to missile crews, the same dynamics exist. They feel so strongly about the magnitude of their responsibilities that they would be totally intolerant of another crew member with that kind of involvement and they would come forward and report substance abuse.

We have good statistics. Those are very low order statistics.

Senator HUMPHREY. With regard to flight crews and missile launch crews you depend on self-reporting and peer reporting?

General OAKS. Well, peer reporting and commander involvement. We would not expect self-reporting to solve the problem. We would not expect that, but we would expect the commander to be aware of what is going on as well as peers.

Senator HUMPHREY. How about in the Navy and Marine Corps regarding their pilots, do you have any special focus on those crews?

Admiral MULLOY. Besides the DOD survey we do our own and we are going to have another one in the January–February timeframe. We take air, surface, and subsurface, so we know we have a picture of where we stand.

Last year I had them pick up the officers in the jails and I am glad to report that was almost minuscule. There is one coming up, when we look into the alcohol thing, we will get a better handle on it. We will take each element because they are all vulnerable.

Senator HUMPHREY. Your system regarding aircrews functions the same way as the Air Force, relying on other people picking up symptoms and reporting those who are affected?

Admiral MULLOY. With the urinalysis thing we are going to catch them anyway and then surveillance catch them. The commander plus the peer group plus the awareness training thing we have and now this meeting we had 2 years ago with all CINC reps, we brought them here to look into the alternatives on the alcohol situation, the breathalizer issue came up.

We are going to pilot program both afloat and ashore how we do this and still keep the combat readiness attitude and not the witch hunting.

General OAKS. Along that same line for every fatal aircraft accident, for every one involved there is a blood alcohol test conducted. It is an after-the-fact indicator, but it is still an indicator for every fatal accident, for everyone involved, a blood alcohol test is conducted.

We have no indication that any of the fatal accidents over the past 3 years have been caused by drug or alcohol abuse.

Senator HUMPHREY. How about the marines and Marine Corps in that respect?

Admiral MULLOY. The same. It is mandatory.

Senator HUMPHREY. Gentlemen, thank you very much. We will submit written questions to you.

[Questions with answers supplied follow:]

Questions Submitted by Senator Roger W. Jepsen

EFFECTS ON MILITARY READINESS

Senator Jepsen. What effects do drug and alcohol abuse have on military readiness?

What studies are ongoing to measure these effects?

What follow-up has been taken on studies previously done to measure these effects?

Dr. Johns. To date the Department of Defense has not conducted formal research on the effects of drug and alcohol abuse on military readiness because the research paradigm that would be required to assess military impairment resulting from such abuse would be extremely complex and expensive to implement.

The effects of drugs and alcohol on military performance would likely vary as a function of:

(1) Type of psychoactive substance,
(2) Specific nature of military task involved,
(3) Degree of skill level by the user,
(4) Complexity of the task,
(5) Drug and alcohol effects on performance in interaction with other likely combat stressors such as noise, overblast, heat, encapsulated environments, fear, etc.

Beyond this it is important to distinguish effects of substances on performance as acute, chronic, or withdrawal.

While drug and alcohol abuse likely impair performance in critical combat skills, such abuse may have more subtle but nevertheless more profound effects such as eroding unit morale and confidence of troops, creating dissension between line troops and their military leaders, and encouraging other antisocial behaviors.

NAVY

Admiral Mulloy. Commonsense tells us drug and alcohol abuse affects an individual's ability to perform specific tasks. Since the beginning of Navy's War on Drugs in February 1982, no ship or squadron of aircraft has reported nonoperational due to drug or alcohol abuse. In fact, overall unit operational and personnel readiness have improved by 10 percent and 17 percent, respectively, over that period of time. Retention for first, second term and career personnel has increased from 54.1 percent in fiscal year 1981 to 63.3 percent in fiscal year 1982, an increase of 9.5 percent, as reported by the CNO retention team. While the Navy's War on Drugs may not have directly contributed to the rise in these readiness indicators, commander's and individual comments indicate that an indirect positive impact has taken place.

No specific studies have been conducted by Navy to measure the effects of drug and alcohol abuse on readiness.

Although no studies have been done with regard to readiness, the impetus for Navy's War on Drugs was the 1980 DOD Worldwide Survey of Nonmedical Drug Use and Alcohol Use Among Military Personnel, which indicated unacceptable levels of drug abuse by junior enlisted personnel.

AIR FORCE

General Oaks. The potential impact on readiness that can be caused by drug and alcohol abuse continues to be a concern to commanders at all levels. While drug and alcohol abuse can impact upon the productivity of the individual, we have no knowledge of any unit having its readiness jeopardized by drug or alcohol abuse. The readiness of our operational units is tested at least annually by Operational Readiness Inspections. These inspections have not indicated any unit's readiness having been jeopardized or downgraded by drug or alcohol abuse. Other than these comprehensive, recurring inspections, no additional studies have been conducted. We feel this lack of overall impact is a credit to our people, and the consistent efforts of our commanders to deter drug and alcohol abuse. If a drug or alcohol problem were identified during an ORI the commander would take corrective action.

MARINE CORPS

General Mead. Drug/Alcohol Abuse affect readiness in many ways from demonstrated inability to accept orders to actual reduction in productivity, unit pride/

cohesion, and rapid response. It is critical, particularly with the highly mobile, rapid response commitments of the Marine Corps, that personnel maintain a high state of readiness at all times; any deviation from this posture is detrimental to effective/efficient operations. While aware philosophically of impacts on readiness, the Marine Corps has been dissatisfied with the inability of previous studies and other management tools to adequately measure this effect. Consequently, the Marine Corps administered a drug and alcohol survey to over 17 percent of the Marine Corps during June 1983. While maintaining anonymity, the survey attempts to quantify readiness impacts by, regions and career communities. If successful, this area will be further developed in planned future biennial surveys. Additionally, the Marine Corps is attempting to develop an automated reporting system to enhance drug and alcohol related reporting.

DETECTING ALCOHOL INTOXICATION

Senator JEPSEN. What programs are underway or planned to detect alcohol intoxication on duty?

Has consideration been given to using random breath or urinalysis in the military workplace for alcohol intoxication?

If not, why not?

Dr. JOHNS. Tab A addresses an April 29, 1983, Department of the Army policy specifying a blood alcohol concentration to determine alcohol intoxication on duty. A similar policy is being considered for OSD-wide implementation.

[The information follows:]

TAB A

HEADQUARTERS,
DEPARTMENT OF THE ARMY.
Washington, D.C., 29 April 1983.

AR 600–85, Interim Change No. I03, Expires 29 April 1985.

Personnel—General

ALCOHOL AND DRUG ABUSE PREVENTION AND CONTROL PROGRAM

Justification: Interim change aligns the policy and use of alcohol breath measuring devices with that of urinalysis. It establishes a standard that a soldier will not have a blood alcohol level of .050% (milligrams of alcohol per 100 milliliters of blood) or above while on duty. The violation of this standard provides a basis for disciplinary action under the UCMJ and basis for administrative action, to include the characterization of a discharge.

Expiration: This interim change expires 2 years from date of publication and will be destroyed at that time unless sooner rescinded or superseded by a permanent change.

1. AR 600–85, 1 January 1982, is changed as follows:

Page 1–4: Paragraph 1–9.1 is added as follows:

1–9.1. Acohol impairment: Military personnel on duty shall not have a blood alcohol level of .050% (milligrams of alcohol per 100 milliliters of blood) or above. Any violation of this provision provides a basis for disciplinary action under the UCMJ and a basis for adminstrative action, to include the characterization of discharge. Nothing in this regulation shall be interpreted to mean that impairment does not exist if the blood alcohol level is less than .050%. To be in violation of this provision, a service member must have known or should reasonably have known prior to becoming impaired that he or she had duties to perform.

Page 3–2: The following sentence is added to the beginning of paragraph 3–5:

Biochemical identification can be accomplished by either urinalysis or alcohol breath testing methods.

Page 3–2: The following sentence supersedes the first sentence of paragraph 3–8b:

The commander will refer all individuals who are suspected or identified as drug and/or alcohol abusers, this includes identification through urinalysis and blood alcohol tests.

Page 3–3: The following sentence supersedes the next to the last sentence of paragraph 3–12:

Service members with blood alcohol levels of .050% or above while on duty will be referred to the ADAPCP.

Page 3–4: Paragraph 3–16a is superseded as follows:

Concept: Biochemical testing for controlled substances or alcohol is a tool for the commander to use for the purposes listed in (1) through (6) below. In addition, biochemical testing is also a tool for the physician to use for the purposes listed in (1), (2), and (5) below. Individuals may use alcohol breath test for the purpose listed in (6) below. Biochemical testing will be conducted with maximum respect and concern for human dignity. Tests may be taken:

(1) To determine a members' fitness for duty and the need for counseling, rehabilitation, or other medical treatment.

(2) To determine the presence of controlled substances in a member's urine or blood alcohol content during participation in the ADAPCP.

(3) To gather evidence to be used in actions under the Uniform Code of Military Justice (UCMJ).

(4) To gather evidence to be used in administrative actions.

(5) To determine the presence of controlled substance in a member's urine or blood alcohol content for a valid medical purpose.

(6) To serve as a safeguard at social gatherings where alcohol beverages are served to individuals who might otherwise not realize how much alcohol they have consumed.

Page 3–6: The following sentences supersede the first three sentences in paragraph 3–16b(1):

(1) Commander—directed: Commanders may direct individual service members, parts of units, or entire units to submit to urine or alcohol breath testing in one or more of the ways listed below. The decision to test is a command judgment. Urine and alcohol tests will be conducted at the unit, or elsewhere the commander directs.

Page 3–6: Paragraphs 3–16b(1)(a) to 3–16b(2)(a) are superseded as follows:

(a) When there is reasonable suspicion a member is using a controlled substance or has a blood alcohol level of .050% or above while on duty, a urine or alcohol test for the medical purpose under Military Rule of Evidence 312(f) of determining the member's fitness for duty and the need for counseling, rehabilitation, or other medical treatment. (See Table 6–1 for limitations on use of the results produced by this method.)

(b) A urine or alcohol breath test as a search or seizure under Military Rules of Evidence 312, 314, 315, and 316.

(c) A urine or alcohol breath test of part of the unit, or entire unit, as an inspection under Military Rule of Evidence 313 for the purpose of preserving the health of the service member inspected (Military Rule of Evidence 312(f)), or for any other inspection purpose.

(2) Physician-directed: Physicians may direct a service member patient to submit to a urine or alcohol breath testing:

(a) When the physician suspects the member of using a controlled substance or abusing alcohol to ascertain whether the member requires counseling, treatment, or rehabilitation in the ADAPCP (See Table 6–1 for limitations on the use of results produced by this method);

Page 3–8: Section V, paragraph 3–19 to 3–21 are added as follows:

SECTION V ALCOHOL BREATH MEASURING DEVICES

3–19. Distribution: Distribution will be IAW CTA 50–909.

3–20. Operator certification: If the alcohol breath measuring device results are to be used in disciplinary or administrative proceedings, the operator must be certified. Certification training should be in accordance with Appendix E, AR 190–5. The installation is responsible for the certification of operators.

3–21. Maintenance: The maintenance of the purchased device is the responsibility of the purchasing installations.

Page 6–2: Paragraph 6–3a(5) is superseded as follows:

Evidence concerning illegal drug or alcohol use or possession of drugs incidental to personal use obtained as a result of a member's emergency medical care for an actual or possible drug or alcohol overdose, unless such treatment resulted from apprehension by law enforcement officials, military or civilian.

Page 6–2: Paragraph 6–3a(1) is superseded as follows:

(1) Mandatory urine or alcohol breath test results taken to determine a member's fitness for duty and to ascertain whether a member requires counseling, rehabilitation, or other medical treatment; or in conjunction with a member's participation in ADAPCP. (See paragraph 3–16b and Table 6–1.)

Page 6–5 : Table 6–1 is superseded with attached table 6–1.
Post these changes per DA Pam 310–13.
3. File this interim change in front of AR 600–85.
By Order of the Secretary of the Army :

E. C. MEYER,
General, U.S. Army,
Chief of Staff.

Official :

ROBERT M. JOYCE,
Major General, U.S. Army,
The Adjutant General.

Distribution : Active Army, ARNG, USAR : To be distributed in accordance with DA Form 12–9A requirements for AR. Personnel General—A.

TABLE 6-1 USE OF MANDATORY URINE OR ALCOHOL BREATH TESTING RESULTS

WAYS A COMMANDER MAY DIRECT URINE OR ALCOHOL BREATH TEST	REFERRAL TO ADAPCP	DISCIPLINARY ACTION UNDER UCMJ	CHARACTERIZATION OF DISCHARGE	OTHER[1] ADMINISTRATION ACTION
TO DETERMINE[2] FITNESS FOR DUTY AND THE NEED FOR COUNSELING, REHABILITATION, OR OTHER MEDICAL TREATMENT	YES	NO	NO	YES
PARTICIPATION IN ADAPCP	YES[3]	NO	NO	YES[4]
SEARCH OR SEIZURE UNDER MILITARY RULES OF EVIDENCE 312, 314, 315 AND 316	YES	YES	YES	YES
AS PART OF A MILITARY INSPECTION UNDER MILITARY RULE OF EVIDENCE 313	YES	YES	YES	YES
WAYS A PHYSICIAN MAY DIRECT URINE OR ALCOHOL BREATH TESTS:				
ASCERTAIN WHETHER A MEMBER REQUIRES COUNSELING, TREATMENT, OR REHABILITATION FOR DRUG OR ALCOHOL ABUSE	YES	NO	NO	YES
OTHER VALID MEDICAL PURPOSE	YES	YES	YES	YES

[1]For example, withholding pass privileges (AR 630-5); admonition and reprimand (Chapter 2, AR 600-37); revocation of security clearances (Chapter 10, AR 604-5); bar to reenlistment (AR 600-80); and suspension of PRP certification (AR 50-5, AR 50-6); see generally FM 27-10, Legal Guide for Commanders.

[2]This category refers to a soldier for whom the commander has a reasonable belief has ingested drugs or alcohol as opposed to probable cause that the soldier has ingested drugs or alcohol. See your local SJA if in doubt.

[3]For members enrolled in ADAPCP, can be used to determine whether further rehabilitation efforts are practical UP Chapter 9, AR 635-200.

[4]However, for members enrolled in ADAPCP, discussion of ADAPCP participation in EERs and OERs must be in accordance with AR 623-105 or AR 623-205. In addition, the fact that a member is participating in ADAPCP should be revealed only to those with an official need to know, see paragraph 6-1b.

ARMY

General MITCHELL. On April 29, 1983, the Army implemented a policy which established an on-duty alcohol impairment standard of 0.05 percent or above; that is, a soldier on duty with a blood alcohol content above this level will be considered impaired on duty. Percent is based upon milligrams of alcohol per 100 milliliters of blood. Any violation of this provision can be used as a basis for disciplinary action under the Uniform Code of Military Justice (UCMJ) and as a basis for administrative action, to include characterization of discharge. Additionally, commanders were authorized to use alcohol breath tests for the following purposes:

(*a*) To determine a service member's fitness for duty and the need for counseling, rehabilitation or other medical treatment.

(*b*) To determine the blood alcohol content of a soldier who is participating in the rehabilitation program.

(*c*) To gather evidence to be used in disciplinary or administrative actions against a soldier.

(*d*) To determine blood alcohol content for valid medical purpose.

(*e*) To serve as a safeguard at social gatherings where alcoholic beverages are served to individuals who may not otherwise realize how much alcohol they have consumed.

NAVY

Admiral MULLOY. Navy is currently planning a 6-month pilot program to evaluate the effectiveness of possible applications of breath analysis equipment to detect alcohol intoxication. To make sure we identify and resolve any problems connected with wider use of breath testing equipment we are selecting units of different sizes both afloat and ashore to participate in this program.

Navy is considering use of breath analysis equipment coupled with 0.05 percent blood alcohol content to trigger a competence for duty examination when in a duty status. Exact procedures for implementation and appropriate setting for use of breath analysis equipment will be developed once our 6-month evaluation of the equipment is complete.

AIR FORCE

General OAKS. The Air Force is currently testing several preliminary breath testing devices. These machines, if approved for use, will be made available for use by local commanders. Currently, commanders have breath analysis/blood alcohol evaluation capabilities available through the base surgeon. Commanders refer for evaluation those members suspected to be unfit for duty due to alcohol abuse. We feel that properly trained supervisors (i.e. those receiving DOD mandated training) are reasonably able to detect impaired employees in the workplace.

MARINE CORPS

General MEAD. The Navy and Marine Corps are developing protocol for a 6-month pilot program which will test both a random breathalizer concept and an appropriate "at work" alcohol influence level (possibly .05 BAC).

SEARCHES OF OVERSEAS MAIL

Senator JEPSEN. What has been the experience with the program instituted in mid-1982 which permits military commanders and judges to authorize searches of mail in overseas areas?

How many searches have been authorized and in what areas?

What types and amounts of contraband have been seized as a result of such searches?

Has this procedure been ruled upon by any civilian or military appellate court?

Dr. JOHNS. Since the amendment of the postal agreement in August 1982 (Tab A) mail has actually been opened under the new policy a total of 25 times. Only nine of these parcels opened contained positive illegal contents. A listing of this data is provided in Tab B. Public information regarding this policy has proven an excellent deterrent based on commanders' expectations of high volume seizures and relatively few actual confiscations. Of the nine actual seizures, two resulted in disciplinary action taken against the addressees and in three cases ("stolen property" and illegal drugs) investigation continues. No action was

taken in the remaining four cases because of insufficient evidence. The results of those actions have been published in installation newspapers and in daily/weekly bulletins. Commanders believe that public knowledge concerning scrutiny of the mail has severely curtailed attempted circumvention of governing regulations. DOD policy therefore, has successfully permitted overseas commanders to protect the expeditious delivery of that mail which carries goods not restricted by law or status of forces agreement.

We believe the new DOD policy is a necessary safeguard to insure the mail is not used as a conduit for illegal drugs and other contraband.

To the best of our knowledge the procedures established as a result of the amended agreement have not been challenged in any civilian or military court.

TAB A

THE SECRETARY OF DEFENSE,
Washington, D.C., August 20, 1982.

Hon. WILLIAM F. BOLGER,
The Postmaster General,
Washington, D.C.

DEAR BILL: I am enclosing a signed copy of the amendments to the 1980 Postal Agreement concerning mail security overseas. I would like to express my deep appreciation for your assistance in acting on this difficult matter. The participation of the Postal Service has been in the best tradition of intra-governmental cooperation.

I would particularly like to commend your General Counsel, Louis A. Cox, along with W. Allen Sanders and Charles R. Braun of his staff, for their excellent work in helping to complete this action. Their professional advice and thoughtful assistance has been most appreciated by the Department of Defense.

Sincerely,

CASPAR W. WEINBERGER.

Attachment.

AMENDMENT OF THE POSTAL AGREEMENT BETWEEN THE UNITED STATES POSTAL SERVICE AND THE DEPARTMENT OF DEFENSE

The Department of Defense and the United States Postal Service hereby amend the Postal Agreement of February 22, 1980, its Appendix A, and the Supplemental Postal Agreement: Administrative Details, as follows, effective when signed by both parties.

1. Section IV.A.3. of the Postal Agreement is amended to read as follows:

"3. Administer the military postal service in accordance with law, and policies and regulations of the Postal Service, and with consistent implementing directives of the Department of Defense, except that the Department of Defense shall determine its own policies and regulations for the privacy of mail, security of mail, and information about mail in the military postal service overseas.".

2. Appendix A is amended by adding the following definition:

"Overseas means any place outside the 50 states or the District of Columbia in which the United States Postal Service does not operate a civilian post office.".

3. Section V.A. of the Supplemental Agreement is amended by adding the following at the end thereof.

"3. Assume financial responsibility, under military claims procedures, for any claims against the United States (including the United States Postal Service) arising out of any inspection, search, or seizure of mail in the military postal service overseas ordered by personnel of the U.S. armed forces.

"4. Notify the Postal Service of any official seizure of mail articles or items from mail articles in the military postal service overseas within a reasonable period of time, not to exceed 30 days after such seizure.".

For the Department of Defense:

CASPAR W. WEINBERGER.
Date August 20, 1982.

For the United States Postal Service:

WILLIAM E. BOLGER.
Date August 12, 1982.

TAB B

SEARCH AND SEIZURE AUTHORITY

DOD/USPS Agreement, Nov 82: Authority given to commanding officer with special court martial authority.

Written report of each actual opening rendered to MPSA; legal review as required.

Common detection methods: Dog alert, fluoroscope, custom tag inspection.

Congressional inquiry, Jul 83, relative to number of openings and drug confiscations since implementation.

With approximately 80,000 tons of mail delivered to overseas command since Nov 82, only 25 parcels have actually been opened.

U.S. Army	1
U.S. Navy	7
U.S. Air Force	17
U.S. Marine Corps	0

Positive illegal contents: 9.

Marihuana	7
Alcohol	1
Stolen government property	1

Seizure results:

Disciplinary	2
Continuing investigation	8
Insufficient evidence	4

Policy not departure from mail sanctity, but necessary safeguard against illegal drug/contraband traffic.

NAVY

Admiral MULLOY. The Military Postal Service Agency requested feedback from overseas commanders on this issue in June 1983. The Military Postal Service Agency indicated mail has actually been opened under the new policy a total of 25 times. Of those 25 occasions, 23 were based on probable cause that the mailed item contained illegal drugs and the other two were searched because of suspicious information contained on the customs declarations. Guidelines outlining the new Department of Defense regulations on inspections and search of Military Postal System mail overseas is contained in change-one to OPNAVINST 5112.4. As to the specific amounts of and types of contraband seized, the Military Postal Service Agency would be best able to answer that question as the cognizant agency. In general, reports from deployed commanders indicate that wide dissemination of public information, as well as media attention and command information/education regarding the results of postal seizures, have contributed to an atmosphere of deterrence from using the Military Postal System as a conduit of contraband. To the best of my knowledge the new regulations have not been challenged in the courts; however, more specific information might be obtained from the General Counsel's Office.

AIR FORCE

General OAKS. To be answered by the Office of the Assistant Secretary of Defense of Health Promotion as per conversation with Dr. John Mazzuchi (OASD–HP).

MARINE CORPS

General MEAD. The Marine Corps has not utilized the authority to search mail, as authorized in DOD Postal Manual (DODINSTRU 4525.6M).

CORRECTING RECORDS OF MILITARY PERSONNEL

Senator JEPSEN. What actions are being taken to correct the records of military personnel whose urine samples were classified as positive at the Oakland Naval Laboratory without full compliance with applicable regulations or procedures?

Has DOD directed a uniform policy on the correction of such records?

If not, why not?

Dr. JOHNS. Each service witness will provide information regarding the first part of your question.

No. Such action is entirely within the scope of responsibilities of each service Secretary.

ARMY

General MITCHELL. The Army was notified in May 1983, of the problems involving the two Naval laboratories and at that time was provided a listing of 1,050 specimens and last four of the SSN which had been erroneously identified as positive. Since then the Army has been identifying individuals affected, screening records, and is currently in the process of notifying all individuals involved. All personnel who were erroneously identified will be informed of the mechanisms available in seeking redress of any injustices incurred as a result of these urine results. Out of the initial 1,050 specimens, 881 individuals were actually identified (the remaining 169 specimens represented duplicate urine tests on the same individual.) To date records screening has determined that only 44 adverse actions appear in any of the files. In September 1983, the Navy provided us with an additional 312 specimen results that had been evaluated as improperly tested. The Army is currently identifying these individuals as well. The Army expects to have completed notification of all individuals erroneously identified by the 1,362 specimens by December 1, 1983. The notification will include information on how to obtain assistance in seeking redress for specific injustices. In order to facilitate and expedite corrective actions, the Army Board of Corrections to Military Records has been designated as the central agency in charge of reviewing those cases where individuals seek redress and effecting the necessary corrections.

NAVY

Admiral MULLOY. A full scale identification process is underway to pinpoint those individuals who were affected in any way by the reversed confirmations. As they are identified, the individuals and their current commanding officers are notified so that a thorough records correction and corrective actions process can commence at the command level. Simultaneously a complete records review and corrective action process takes place at the headquarters level in Washington.

DOD has allowed each service to independently correct records as a result of the reversals reported by the Oakland laboratory. The authority for the comprehensive correction of naval records is complete within the Department of the Navy.

AIR FORCE

General OAKS. With regard to a uniform policy on the correction of records, the DEPSECDEF directed that each service take prompt corrective action to insure that no member suffers any permanent adverse action resulting from improperly classified urine samples. In keeping with this policy, the Air Force initiated the actions outlined below to insure no current or former Air Force member suffers any adverse action. The uniqueness of each military department makes it necessary for each service to conduct independent record correction programs.

The Air Force Manpower and Personnel Center (AFMPC) is working to rectify actions taken as a result of samples improperly processed by the Oakland Navy lab during fiscal year 1982. None of these should have resulted in disciplinary action or characterization of discharge less than honorable because we had not yet implemented the chain-of-custody provision on urinalysis testing. However, numerous administrative actions could have occurred. The Air Force MPC has identified 653 current and former Air Force members who may have been impacted by the laboratory errors. This was completed by September 15, 1983. Individuals still on active duty will be advised by letter of the improperly conducted tests; be interviewed by and have his/her records reviewed by the Consolidated Base Personnel Office (CBPO). They will then be counseled regarding administrative appeal procedures available to rectify any adverse actions taken resulting from one or more questionable urinalysis tests. Letters of notification and instructions for the CBPOs are being prepared at this time.

The master personnel records for those persons separated are being reviewed at AFMPC to determine whether one or more of the questionable urinalysis tests contributed in whole or in part to a member's separation. If so, the affected separated member will be advised in writing of his/her right to petition the Air Force Board for Correction of Military Records (AFBCMR) for a review of their case.

They will also be advised that the CBPO at the nearest Air Force base will assist them in preparing the applications to the AFBCMR.

MARINE CORPS

General MEAD. The Marines Corps was fortunately spared major involvement; only 86 Marines involved in first period invalidation (1 Jan to 15 Sep) and possibly 95 additional cases in extended period (16 Sep to 17 Oct). Correction steps proceeded as follows: confirmation of service affiliation on original cases; specific identification of Marine/actions to be redressed; development/approval of correction plan; implementation of correction plan; receipt of possible additional cases from the extended period. To date all action completed on original cases, except four cases requiring sequential action. Wherever possible, Marine Corps assumed correction responsibility. Specific identification has begun on recently received additional cases.

DOD has not directed a uniform correction policy. A common system would be illogical and preclude responsive correction. The Marine Corps' impact is extremely small both in total numbers and severity of action to redress. Consequently, it has been possible to immediately and completely redress these cases without waiting completion of more complex Army/Navy/Air Force cases.

URINALYSIS DETECTION

Senator JEPSEN. Is the urinalysis detection program viewed as a law enforcement or quality force program, or both?

How is a determination made whether action will be taken under the Uniform Code of Military Justice or under some other procedure as a result of a positive urinalysis?

Dr. JOHNS. Detection of drug abuse by urinalysis is viewed by the services as a quality force issue.

The primary reponsibility for determining an appropriate disposition in each case rests with the immediate commander. Each service has provided guidance tailored to the specific needs of that service.

ARMY

General MITCHELL. The drug urinalysis program is valuable as a drug use deterrent, it is a commanders program. In addition to its powerful deterrent effect, it is designed to be operated at the lowest level of command and provides those commanders with the mechanism to effectively identify and deal with drug abusers. The decision as to how positive urinalysis results will be used is a commanders responsibility. The decision as to what actions should be considered are based on the circumstances involving abuse, the individual's record, and the individual's potential for future useful service. In those instances where a urine specimen is taken based on a search or seizure, or as part of a military inspection; the results may be used as evidence under the Military Rules of Evidence in disciplinary and/or characterization of discharge actions.

NAVY

Admiral MULLOY. Drug abuse undermines the very fiber of combat readiness, safety, discipline, judgment and loyalty and is particularly detrimental to morale and espirit de corps. The Navy's urinalysis detection program is designed to eliminate drug abuse and thus strengthen those principles which are so necessary to our national defense. Disciplinary action taken under the Uniform Code of Military Justice is secondary to providing an identified individual the help he/she needs to cease abusing drugs and be restored to full duty status. Disciplinary action, however, does reinforce the fact that an individual has performed an illegal action and serves as a strong deterrent to future illegal acts by that individual and, most importantly, by his/her peers. Urinalysis is both an enforcement and quality of life program in that it inhibits and punishes willful drug abuse but also provides a means of identifying those who need help. As shipmates take up the War on Drug Abuse, the fitness of all hands, the health, good order and discipline, readiness and retention will improve and the resultant environment is an improvement in quality of life.

Determination of the degree of disciplinary action taken under the Uniform Code of Military Justice, if any, or other action necessary is made by the individ-

ual's commanding officer utilizing all evidence available, including recommendations by immediate supervisors and past performance.

AIR FORCE

General OAKS. The urinalysis detection program demonstrates an interdependent relationship between military law enforcement and the quality force program. The decision to process the case under the other procedure is dependent on the commander's judgment and decision as to what is appropriate in a particular case. The severity of the offense, the past record and status of the individual, the state of discipline within the command and the manner in which the urinalysis specimen was obtained are all factors upon which the commander bases a decision.

MARINE CORPS

General MEAD. As the major drug abuse detection/deterrence system, urinalysis is the keystone of success in the Marine Corps "War on Drugs," a program developed from readiness and people-oriented concerns. While probable cause urinalysis is normally conducted through law enforcement channels, the preponderance of urinalysis is command controlled random sampling which may or may not result in adverse disciplinary or administrative action.

The urinalysis testing system can only detect presence of a drug; not legality/illegality of the presence, amount/frequency of use, or impairment. Consequently, on receipt of confirmation of drug presence under this program the commanding officer must assess the situation to determine if an offense may have occurred and determine the most appropriate action to resolve the issue.

ACTION RESULTING FROM POSITIVE URINALYSIS

Senator JEPSEN. Has DOD directed a uniform approach for action resulting from positive urinalysis?

If not, what approaches do each service follow?

What is the basis for any difference in the basic approaches?

Dr. JOHNS. No.

Defer to services for individual policies.

The Deputy Secretary of Defense memorandum dated December 28, 1981, which has been incorporated into the DOD Directive on urinalysis testing issued in March 1983 removed prohibitions from using urinalysis results to suport disciplinary actions under the UCMJ or to support characterization of administrative discharges. It was permissive not directive in nature. The services have taken differing approaches to the implementation of this policy.

ARMY

General MITCHELL. On August 17, 1982, the Secretary of the Army and the Chief of Staff of the Army established a standard that stated drug and alcohol abuse was incompatible with military service. Since that time, the Army has implemented policies dealing with selected categories of drug abusers aimed at reenforcing the standard as well as emphasizing the individual's responsibility to uphold Army Regulations. Specifically, the policies which became effective July 1, 1983, mandate the initiation of separation proceedings for any officer or senior enlisted person (E6–E9) identified as a drug abuser, soldiers who are identified as second time offenders, or soldiers determined to be drug dependent. These policies do not mandate separation. The decision as to final disposition of individuals rests at various senior level commanders. All soldiers who are identified as drug abusers are referred to the Army's Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) to determine the degree of abuse. When in the opinion of the commander and ADAPCP staff the individual possesses potential for future useful service, rehabilitation will be provided as necessary.

NAVY

Admiral MULLOY. DOD has laid down guidelines for the use of urinalysis results in DOD Instruction 1010.1 dated 16 March 1983. Further guidance is provided to Navy commanders in OPNAVINST 5350.4 of November 29, 1982.

Navy's approach to the use of urinalysis results is based on our perception of the threat drug abuse poses to readiness, safety, discipline, judgment, and loyalty.

Specific actions taken based on the results of a urinalysis test depend on the individual case. If disciplinary action is warranted, the individual's commanding officer, utilizing all evidence available, will determine the degree of action to be taken.

Any differences in the basic approaches employed by each of the services is a result of differences in operating environments, force composition, and unique needs of the various services. Our basic aim is to be rid of the abuse, not necessarily the abuser in every case.

AIR FORCE

General OAKS. DOD has issued uniform policy on the use of drug abuse evidence obtained as a result of urinalysis. This policy is expressed in Department of Defense Directive 1010.1. The directive provides instruction as to when urinalysis may be conducted under specific military rules of evidence contained in the Manual for Courts Martial, issues specific guidelines on the use of urinalysis results and provides limitation on the use of urinalysis evidence in actions taken under the Uniform Code of Military Justice or in characterization of discharge. Each service must follow the policies and procedures established by the Department of Defense on the use of urinalysis results. The Air Force has not issued further instructions on the use of urinalysis results. If as a result of a urinalysis positive a commander determines drug abuse has occurred, disciplinary action or separation may be recommended by the commander under the guidelines of Department of Defense Directive 1010.1.

MARINE CORPS

General MEAD. No; services and commanders must be allowed as much flexibility as possible when dealing in area of unit readiness and dicipline?

In the Marine Corps, all officers are discharged, as is any Marine involved in trafficking drugs. Enlisted Marines are normally retained for a first offense, contingent on the command assessment of the Marines future potential and his willingness to adopt to Marine Corps standards. Different programs are required to support vastly different service demographic situations, traditional philosophies, and missions.

LEVELS OF DRUG AND ALCOHOL USAGE

Senator JEPSEN. How do the levels of drug and alcohol usage in the armed services as reflected in the 1982 worldwide survey compare with the levels of such usage among similar age groups in American society at large?

Dr. JOHNS. The following table contrasts 30-day rates of drug and alcohol usage between military and civilian male samples. These samples have been statistically balanced for age, marital status, and education.

	Military		Civilian	
Drug:				
Alcohol	85.6	(0:5)	75.7	(3.9)
Marihuana	25.1	(.6)	34.7	(4.4)
LSD/hallucinogens	3.8	(.3)	2.4	(1.0)
Cocaine	4.6	(.3)	9.4	(1.9)
Stimulants	6.9	(.3)	4.9	(1.5)
Tranquilizers	1.7	(.2)	1.7	(.9)
Heroin	.7	(.1)	0	

While drinking is more common among military personnel than among their civilian counterparts, use of marihuana is rarer in the military. Ingestion of other drugs is fairly comparable in the two populations. It is interesting that although abuse of stimulants remains somewhat more common in the military than in the civilian community, in 1980 stimulant abuse was two and a half times more common in the military than in the civilian sample.

General MEAD. In comparing alcohol usage among similar groups in American society at large and in the Marine Corps, we appear to use alcohol in greater percentages. However, marijuana use among the same two groups is less in the Marine Corps.

DRUG REHABILITATION PROGRAM

Senator JEPSEN. How many persons in each service were entered into a drug rehabilitation program during 1982?

Into an alcohol rehabilitation program?

How many persons entered into such a program were ultimately discharged for drug or alcohol-related reasons?

ARMY

General MITCHELL. In fiscal year 1982, 10,845 soldiers were entered into the rehabilitation program for drug abuse, and 13,165 were entered for alcohol abuse. During that time, 1,124 were discharged for drug abuse, and 2,441 were discharged for alcohol abuse.

NAVY

Admiral MULLOY. During fiscal year 1982 910 Navy personnel entered drug rehabilitation of which 122 individuals who failed treatment were terminated from treatment and returned to their command for further disposition, which could result in separation or retention depending on the circumstances of the individual case.

The alcohol rehabilitation centers admitted 4,573 clients for treatment, of which 1,323 members who failed treatment were terminated and returned to their command for further disposition, which could result in separation or retention depending on the circumstances of the individual case.

Statistics are not maintained concerning discharge disposition of personnel who have attended treatment; however, past studies have shown that 82.2 percent of the personnel age 26 and older who complete alcohol treatment are successful in completing their naval career.

AIR FORCE

General OAKS. During fiscal year 1982, 5,892 Air Force members were entered into drug rehabilitation. During fiscal year 1982, 2,848 members were discharged for drug abuse. Additionally, another 156 members were discharged with a primary reason of other than drug abuse (although drug involvement may have been a contributing factor) while they were in rehabilitation. 7,051 were entered into alcohol rehabilitation programs in fiscal year 1982. A total of 2,235 members were separated prior to their normal date of separation while in an alcohol rehabilitation program.

MARINE CORPS

General MEAD. Over 200 Marines entered the Navy Drug Rehabilitation Center at Miramar and 1,128 Marines were treated at one of the Navy Rehabilitation Centers/Services in fiscal year 1983, although many Marines were treated at these facilities for drug and alcohol problems. The success/retention rate is almost 100 percent for Marines completing rehabilitation since future potential had already been assessed prior to authorizing treatment. The Marine Corps also provided local alcohol assistance to almost 12,000 Marines during the same period.

DRUG ABUSE IN OVERSEAS SCHOOLS

Senator JEPSEN. During the joint hearing on this same subject in 1982, it was indicated that a study was being done by drug abuse in DOD overseas schools.

What were the results of that study?

Dr. JOHNS. The table below contrasts use of marihuana, alcohol, and cigarettes for seniors in Department of Defense Dependent Schools (DODDS) with such use in civilian U.S.-based high schools.

TABLE

[In percent]

	DODDS	Stateside
Marihuana:		
Use ever	58	59
Use in last 30 days	27	29
Daily use	4	6
Alcohol:		
Use ever	96	93
Use in last 30 days	79	70
Daily use	8	6
Cigarettes:		
Use ever	76	70
Use in last 30 days	36	30
Daily use	26	21

While use of marihuana is less common in DODDS schools than in stateside schools, use of alcohol and cigarettes is more prevalent in the military schools. Nevertheless, the two groups of high school seniors are generally more alike than different.

MARINE CORPS

General MEAD. The results of the drug abuse study in DOD overseas schools indicates that there is not significant differences in the drug usage rates between students in the DOD Overseas schools and students stateside.

ARMY

General MITCHELL. The Impact of Drug Use on Tank Crew Cohesion, conducted by Walter Reed Army Institute of Research was completed in August 1982. The study included a questionnaire survey from 65 tank crews located in the Federal Republic of Germany. Findings of the study indicated that as soldier responsibilities are increased there is less likelihood of abuse. Additionally, the study concluded that drug usage does adversely impact on a combat situation. Statistics indicate that out of the 65 crews, 30 had only one member who used drugs, and 30 had only two members who used drugs. Only one tank crew contained members who were all drug users. A copy of the report is provided under separate cover. The study has confirmed the Army's belief that drug abuse adversely impacts upon unit cohesion and may foster unwholesome bonding of soldiers based upon drug use. The devastating effect of drug use by leaders directly supported the Army's recent policy to seek elimination of such leaders.

BIOCHEMICAL TESTING PROCEDURES

Senator LEVIN. Are you confident that the biochemical testing procedures that the services are using in their urinalysis programs are 100 percent accurate from a scientist point of view? Please explain your answer.

Dr. JOHNS. The biochemical testing procedures used in the military urinalysis program are scientifically sound; however, no laboratory procedure can be presumed to be 100 percent accurate 100 percent of the time. This is due not to the scientific basis of the procedure itself, necessarily, but to human variables. While it is our policy to eradicate drug abuse from the Armed Forces, we are equally concerned that non drug users not be misidentified. For these reasons DOD policy concerning drug urinalysis is designed to be extremely conservative and to err in favor of the individual being tested. The requirements for two independent chemical analyses, chain of custody from point of collection to completion of laboratory analysis, retention of laboratory reports, and freezing of positive samples for possible retesting are all examples of policy precautions taken to preclude false identifications.

TWO INDEPENDENT CHEMICAL METHODOLOGIES

Senator LEVIN. According to your statement "each urine specimen submitted for drug urinalysis is subjected to two independent chemical methodologies prior to being reported as positive for the presence of a drug."

Yet, recent press reports indicate that up to 6,000 individuals in all three services may have been disciplined by mistake for drug abuse because of faulty testing procedures at two Navy laboratories in California in 1982.

Were each of these 6,000 tests submitted to "two independent chemical methodologies prior to being reported postive?"

Dr. JOHNS. The situation you are referring to is in fact an example of the measures taken to ensure that individuals are not misidentified as drug abusers. Although the problems at both Navy laboratories in California were the consequence of system overloading due to significantly increased testing by the Navy, the circumstances at each lab were different and I will take each one separately. From November 1981 to May 1982 laboratory personnel at the San Diego Naval Drug Laboratory, faced with processing more samples than they could handle, did not use the correct confirmation test in all cases. They performed the labor-intensive gas liquid chromatography test to confirm samples which had been screened positive by radioimmunoassay only on samples they knew were going to be used to support disciplinary action. All others were confirmed with an enzyme immunoassay test. While this test was a separate chemical process, it was not the approved methodology. At this time the Navy was the only military department using urinalysis results to support disciplinary action; the Army and Air Force had not yet implemented the DOD policy changes which permitted

such action. Further, the Navy lab in San Diego supported all military units in a specific geographic region. Army and Air Force units in this region were not made aware of this unilateral decision by the San Diego lab. The Air Force brought the situation to my attention earlier this year which led to the subsequent investigation by the Navy.

The situation at the Oakland laboratory was also a consequence of overloading of the lab system; however, the problems were identified by an independent Naval investigation. Between January 1982 and October 1982 approximately 6,500 samples were determined to have been improperly interpreted or to have had significant administrative errors. Each service will reply in detail as to the specific numbers of individuals involved, and actions taken both to locate those individuals and to make appropriate corrections.

ARMY

General MITCHELL. The Navy conducted an internal investigation as to the specific problems and subsequently informed the Army of generalized results and specific specimens determined to have been affected by the problems. While the Army is aware that there were administrative and procedural problems identified in both laboratories, specific errors found in the testing procedures within the laboratories in question will be addressed by the Navy.

STEPS TAKEN TO PREVENT MISTAKEN DRUG ABUSE

Senator LEVIN. What system failures allowed the approximately 6,000 individuals to be mistakenly identified positive for drug abuse last year? What steps have been taken to prevent these failures at all testing facilities.

Dr. JOHNS. The fundamental problem which caused these errors was an overload of the regional lab system. In August 1982 the lab system was geographically de-regionalized by direction of the Secretary of Defense. This action permitted more direct control of demand and resources within the appropriate military departments. The Navy now provides drug abuse urinalysis for the Navy and Marine Corps, while the Army and the Air Force use a bi-service system. Additionally, a more standardized protocol for the urinalysis procedures, incorporating refinements and improvements, has been developed and is currently under scientific review by the National Institute on Drug Abuse.

ARMY

General MITCHELL. The Army is currently conducting a review of procedures, operations, and specimen results in all Army/Air Force Drug Testing Laboratories to insure that the system is sufficiently accurate and reliable to meet legal and scientific standards. The review is being conducted by a Blue Ribbon Panel established on 24 October 1983 by the Surgeon General of the Army to specifically investigate potential problems within the Fort Meade Drug Testing Laboratory. Subsequent to the evaluation of Fort Meade Laboratory, the Panel will review procedures, operations, and specimen results at the other laboratories as well. Headed by MG Einsel, the panel includes three civilian toxicologists, and military as well as civilian legal advisors. The expected completion date for this review is 15 December 1983. While the Army considers the testing procedures utilized by the Drug Testing Laboratories to be legally sufficient and scientifically accurate in identifying drug abusers, we are attempting to ensure that sufficient safeguards are in place to protect the Army and its soldiers in the implementation of these procedures and the policies that encompass the urinalysis program. DOD authorized the use of urine results taken under search and seizure or as part of a military inspection on 28 December 1981. However, the Army adopted these policies only after there were sufficient laboratory resources and control mechanisms in place. Since the formation of the Joint Army/Air Force Drug Testing System, both services have been conducting periodic reviews of laboratory operations and testing procedures. On a quarterly basis, laboratory managers collectively meet to discuss testing procedures and laboratory operations. In September, a Joint Army/Air Force Drug Testing Standing Operation Procedure was published which insures that standards are applied uniformly among laboratories. Both Services have established an evaluation system which consists of teams that visit the laboratories on a periodic basis to review procedures and operations. The Blue Ribbon Panel mentioned previously is the latest effort by Department of the Army to review procedures and to identify any problems associated with the implementation of these procedures within the testing facilities.

NAVY

Admiral MULLOY. A JAG Manual investigation of lab procedures at the Oakland Naval Drug Laboratory during the JAN–OCT timeframe revealed that some administrative procedures were inadequate, and that during some periods of extremely heavy sample input, probable positive findings were not reviewed by a second lab technician. Errors of technique also occurred during implementation of temporary streamlined procedures designed to deal with the heavier input. Chromatograms were reviewed by a single technologist who was a newly appointed supervisor. There were no problems which reflected upon the scientific validity of the actual testing procedures if performed as mandated.

Corrective actions have been implemented Navywide to preclude additional problems similar to those encountered at Oakland. These include:

The imposition of quotas on urine submissions to drug screening labs.

The assignment of additional personnel (military and civilian) to drug screening labs, required standards for training and certifying operators, and increased funding and equipment.

The utilization of a new chain of custody document which reduced the administrative burden and streamlined administrative procedures.

The establishment of an Ad Hoc Laboratory Drug Urinalysis Coordinating Group to standardize and streamline technical and administrative procedures.

The initiation of a message report back to the submitting command utilizing a standardized message format to decrease turnaround time and reduce administrative requirements.

The development of improved internal quality control standards including the use of a "negative standard" (i.e., a negative control sample previously determined to contain no drugs, as a "gauge" against which to measure levels of the drugs present in the samples being tested.)

The promulgation of a standard operating procedures manual that covers administrative and testing procedures for all drugs.

An inspection of the administrative and technical procedures used in the laboratory is conducted bimonthly by the Naval Medical Command for all the laboratories.

AIR FORCE

General OAKS. Since the errors in question occurred in Navy laboratories, we will defer to the Navy to answer the first question. Regarding the second question, we have taken numerous steps to insure quality processing of Air Force samples. During 1982 we established the Army/Air Force laboratory system. We continue to do quality control testing with Armed Forces Institute of Pathology samples, of which we have never had a false positive since the joint lab system was established. We freeze all positives, allowing retesting or testing at member cost by private laboratories. All requests for mass-spectrometry for court-martial evidence at our Brooks AFB laboratory are being honored. Additionally, our capability to do mass spectrometry quality control analysis in addition to Armed Forces Institute of Pathology testing will be enhanced in the near future with the purchase of additional mass spectrometry equipment which is on order. The Inspector General recently ordered a Field Management Inspection be conducted of the entire laboratory system. We feel these efforts along with constant vigilance will insure the best possible system in the Air Force.

LOCATING MISTAKENLY DISCIPLINED INDIVIDUALS

Senator LEVIN. What is the status of efforts in each of the services to locate those individuals who may have been mistakenly disciplined and make amends? [Question directed to each service witness.]

ARMY

General MITCHELL. The Army was notified in May 1983, of the problems involving the two Naval laboratories and at that time was provided a listing of 1050 specimens and last four of the SSN which had been erroneously identified as positive. Since then the Army has been identifying individuals affected, screening records, and is currently in the process of notifying all individuals involved. All personnel who were erroneously identified will be informed of the mechanisms available in seeking redress of any injustices incurred as a result of these urine results. Out of the initial 1050 specimens, 881 individuals were actually identified

(the remaining 169 specimens represented duplicate urine tests on the same individual.) To date records screening has determined that only 44 adverse actions appear in any of the files. In Sep 1983, the Navy provided us with an additional 312 specimen results that had been evaluated as improperly tested. The Army is currently identifying these individuals as well. The Army expects to have completed notification of all individuals erroneously identified by the 1362 specimens by 1 Dec 1983. The notification will include information on how to obtain assistance in seeking redress for specific injustices. In order to facilitate and expedite corrective actions, the Army Board of Corrections to Military Records has been designated as the central agency in charge of reviewing those cases where individuals seek redress and effecting the necessary corrections.

NAVY

Admiral MULLOY. Of the approximately 4,600 Navy service members affected, approximately 2,100 have been identified by name and Social Security number after six months of intensive effort. The retained laboratory documentation which provided the starting point for the identification process contains only minimal information concerning the identity of the individual providing the specimen. This specimen identification policy was in accordance wth the applicable regulations in effect at the time. This fragmentary data does not, in many cases, identify the individual's current command, noting only the command which submitted the specimen identification policy was in accordance with the applicable regulations the individual attended or a medical facility that "batched" specimens for shipment. Accurate identification of these individuals is a piece of genuine detective work and requires both patience and ingenuity in the larger interest of assuring that nothing is assumed and that no errors are made. The commands that submitted the samples are requested to identify the affected individuals from the data we provide and define exactly what, if any, actions were taken as a result of this specific urinalysis report. Each service member is treated individually, and his/her record is examined at the local command level to document the case in detail.

It is Navy policy that all adverse administrative and disciplinary action taken solely as a result of these reversed confirmations will be rescinded and removed from all records pertaining to the individual's naval service.

AIR FORCE

General OAKS. The Air Force Manpower and Personnel Center (AFMPC) is working to rectify actions taken as a result of samples improperly processed by the Oakland Navy lab during fiscal year 1982. None of these should have resulted in disciplinary action or characterization of discharge less than honorable because we had not yet implemented the chain-of-custody provision on urinalysis testing. However, numerous administrative actions could have occurred. The Air Force MPC has identified 653 current and former Air Force members who may have been impacted by the laboratory errors. This was completed 15 September 1983. Individuals still on active duty will be advised by letter of the improperly conducted tests; be interviewed by and have his/her records reviewed by the Consolidated Base Personnel Office (CBPO). They will then be counseled regarding administrative appeal procedures available to rectify any adverse actions taken resulting from one or more questionable urinalysis tests. Letters of notification and instruction for the CBPOs are being prepared at this time.

The master personnel records for those persons separated are being reviewed at AFMPC to determine whether one or more of the questionable urinalysis tests contributed in whole or in part to a member's separation. If so, the affected separated member will be advised in writing of his/her right to petition the Air Force Board for Correction of Military Records (AFBCMR) for a review of their case. They will also be advised that the CBPO at the nearest Air Force base will assist them in preparing their applications to the AFBCMR.

MARINE CORPS

General MEAD. As previously mentioned, the Marine Corps has identified and corrected action on all but four Marines identified in the Oakland invalidation period from January 1 to September 15, 1982. The Marine Corps is in the identification process to correct records of additional cases invalidated September 16 to October 17, 1982. All action should be completed by the end of November.

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SEPARATION ACTION FOR POSITIVE DRUG ABUSE

Senator LEVIN. Dr. Johns (and each service witness), all of the services have adopted a policy of initiating separation actions for commissioned officers, warrant officers and senior non-commissioned officers who have a single positive identfication of drug use.

Why are all of you confident that your collection, chain of custody, and testing procedures are sufficiently fool-proof to prevent an individual from being falsely accused of drug use? What error rate do you estimate does occur?

Dr. JOHNS. In addition to internal laboratory quality control measures taken by each DOD drug testing laboratory, an external quality control is provided by the Armed Forces Institute of Pathology (AFIP). The requirement for chain of custody and retention of not only all laboratory reports but of the frozen positive sample as well provide an avenue for recourse for individuals who believe they have been improperly identified.

ARMY

General MITCHELL. The Army implemented policies on 1 July 1983 which mandate unit commanders to initiate separation proceedings for officers/warrant officers, and senior enlisted persons (E6–E9) who are identified as illegal drug abusers. These policies do not mandate the separation of drug abusers. A review process takes place prior to the final determination of the separation authority disposition of each case. The testing procedures that are currently used within all Army/Air Force Drug Testing Laboratories have been certified as scientifically sound and accurate in detecting drug abuse. The cut-off levels that are used in identifying drugs is sufficiently high enough to preclude the issue of passive inhalation. DOD requires that two independent tests be conducted on each specimen prior to classification as positive, in Army laboratories all specimens undergo three tests—2 RIA screens, and 1 GLC. Chain of custody procedures provide for a stringent procedure of collection and handling of urine specimens from the time the specimen is taken until the time the results are reported to the commander. The Army has had no reported cases of false positives or errors in identifying negative results as positive through the DOD quality control program operated by the Armed Forces Institute of Pathology since the initiation of the mandated actions for drug abusers. While there have been reports of false negatives, instances where a specimen was supposedly positive but classified as negative by the laboratory, this is an indicator of the stringent standards utilized in the classification of a specimen as positive. While the Army is confident in the procedures and policies established, we are attempting to insure that the implementation of these are sufficient to maintain legal and scientific credibility.

NAVY

Admiral MULLOY. The Navy's confidence in our urinalysis program is rooted in the use of standardized procedures both by the submitting command and the laboratories. In addition the testing methodology used by our laboratories has undergone scientific scrutiny and has been found satisfactory. The specific documents and actions that support our confidence are detailed below.

The Navy's instruction on Substance Abuse Prevention and Control (OPNAVINST 5350.4) delineates procedures for the collection, packaging and transportation of specimens. The collection of the specimen under direct observation, the individual's initials on the specimen bottle label and their signature on a urinalysis collection ledger all serve to establish the origin of the sample and thus begins the chain of custody. Specimens at the unit level are handled by a very limited number of individuals designated and accountable to the commanding officer.

When the sample arrives at the laboratory the strict chain of custody is maintained within the laboratory. Procedures for the handling of specimens in the laboratory and other administrative actions along with the testing procedures to be followed are detailed in the Standard Operating Procedures (SOP) for the laboratory. The use of the SOP by our laboratories has been scrutinized and endorsed by six noted forensic toxicologists, including the President and Vice President of the American Board of Forensic Toxicologists, who have individually visited Navy laboratories prior to providing expert testimony about a particular laboratory's procedures. In addition a technical and administrative inspection of all Navy laboratories is done bimonthly by the Naval Medical Command.

In the 11½ months of fiscal year 1983 since the problems at our Oakland laboratory were corrected the Navy reversed 26 test results previously reported as

positive which is an error rate of .002 percent out of the 1.2 million specimens tested in fiscal year 1983. Additionally, the Armed Forces Institute of Pathology, which is responsible for overall quality control of all DOD laboratories, summary of performance for three quarters of fiscal year 1983, indicated laboratories correctly analyzed 98.04 percent of all quality control samples with zero false positives.

AIR FORCE

General OAKS. The following factors contribute to the high confidence we place in our urinalysis collection, chain-of-custody, and testing procedures. Likewise, their cumulative impact is that our urinalysis system is highly credible in not falsely accusing someone of drug abuse. Immediately following observed collection of the sample, the sample is identified by SSAN as well as other identification data. Written procedures in AFR 160–23 describe the exact steps the urine testing monitor follows from that point until shipping. Shipping procedures disallow tampering of the sample enroute, and procedures at the receiving drug testing laboratory further insure sample integrity throughout the process. The radioimmunoassay (RIA) screening test and gas-liquid chromatograph (GLC) confirmatory test are performed on two different aliquots from the same sample. AFIP quality control results since the formation of our Army/Air Force laboratory system have reported no false positives, demonstrating the credibility and reliability of our system. The chain of custody procedures at all levels have been carefully scrutinized by Air Force judge advocates, who report satisfaction with the legal sufficiency of the system. We are virtually 100 percent certain that individuals shown positive on urine tests did use the drug in question. Also, our consistent screening and confirmatory cut-off of 100 ng/ml for THC virtually rules out the possibility of the positive being attributed to passive inhalation/ingestion of marihuana and adds to the credibility of the positive results.

MARINE CORPS

General MEAD. The Marine Corps utilizes its Navy Drug Screening Laboratories at San Diego, Oakland, Jacksonville, Great Lakes, Portsmouth and a civilian contract laboratory. To date the Navy Laboratories have processed approximately 1.4 million samples with a total error rate of .46 percent. The civilian contractor is required to maintain a 95 percent accuracy rate, however have performed at a 99.8 percent rate on negative samples. No disciplinary action is taken without a laboratory confirmed positive. If any doubt occurs, the sample is retested. The Armed Forces Institute of Pathology guarantees laboratory performance.

USING DRUG URINALYSIS RESULTS

Senator LEVIN. Dr. Johns, are there any companies, or organizations, or civilian law enforcement agency outside of the military that use drug urinalysis results in ways comparable to the military services? Please give some examples if you know of any.

Dr. JOHNS. I have no first hand knowledge of other organizations using urinalysis results in ways comparable to the Military Departments.

Senator LEVIN. (All service witnesses) the services have all emphasized that the one time positive-identification-mandating-separation policy for officers and senior enlisted personnel can be mitigated by the individual's commanding officer.

In each service, since adopting this one-time-out policy, how many officers and senior non-commissioned enlisted personnel have been positively identified under drug urinalysis who were not ultimately separated?

What mitigating factors are considered?

ARMY

General MITCHELL. The Army does not track this type of data on a routine basis. The separation mechanisms and reporting structure within the Army is oriented toward a decentralized approach in the execution of policies and regulatory guidance. Since the adoption of these drug policies in Jul 1983, we have begun to see an increase in the number of separations being directed. However, in both the officer/warrant officer and senior enlisted person category these numbers to date are small, 12 officers have been separated and 3 E6's and above. The policies themselves are a means of enforcing the standard that drug abuse will not be tolerated among soldiers, and especially leaders. The reviewing authorities must consider as in any type of separation action a multitude of factors prior to determining the final disposition of a case. Such issues as the circumstances of

abuse, the individual's past record, and the individual's potential for future useful service are only examples of the type of factors considered by separation authorities in each case. While the Army does not want drug abusers among its leaders, in some instances one time use or the circumstances surrounding the incident may be such that the reviewing authority deems it appropriate to direct other actions. In each case of an officer/warrant officer a board of review is conducted to review the facts and to make recommendations to the reviewing and separating authority. In the case of enlisted persons with over six years of service a board of review is also required.

NAVY

Admiral MULLOY. Data are not presently available on how many officers and senior non-commissioned enlisted personnel were positively identified by drug urinalysis and were not ultimately separated. Information on such actions that do not result in separation are held at the unit level and not submitted to headquarters.

For both officers and enlisted personnel, commanding officers are charged by Navy policy to integrate and analyze all elements of evidence prior to making a determination as to whether drug abuse exists. In addition to the positive urinalysis result some other factors that may act in mitigation are: (1) the individual's performance and service reputation on and off the job, (2) a medical officer's evaluation of the individual, (3) the soundness of the chain-of-custody with regard to the sample in question, (4) the results of a retest conducted on the original samples, and (5) the commanding officer's judgment of the whole man. Once identified as a drug abuser by the commanding officer, an officer's case will be reviewed by as many as three separate boards of officers, any of which may reverse the original findings. Final determination in each case is made by the Secretary of the Navy after a review by the Chief of Naval Personnel. A similar review process takes place for enlisted personnel.

AIR FORCE

General OAKS. A one time positive identification through urinalysis does not mandate separation. If as a result of positive urinalysis a commander determines drug abuse has occurred, separation for drug abuse may take place.

It is Air Force policy that Officer and NCO drug abusers are "usually not retained". Drug abuse by a commissioned or noncommissioned officer is a serious abdication of responsibility and significantly affects their potential for further military service. Such conduct is not taken lightly and separation is usually appropriate and, as a rule, the normal disposition for officer and NCO drug abusers. In all cases of drug abuse the commander must consider the impact of the abuse on the abuser's potential for further military service in making the decision to retain, recommend discharge, and/or take other administrative or judicial action.

No historical data is available which would provide the number of individuals who were identified via urinalysis as drug abusers and who were subsequently separated or retained. In early 1982 the Air Force began a six month study of commander response to drug abuse. This study was designed to develop service-wide data on commander response to drug abuse identified through urinalysis and other methods of identification. Preliminary results indicate that the majority of NCOs identified by commanders through urinalysis as drug abusers are being separated. Similarly, preliminary results for officers reveal over ninety percent of the officers identified as abusers are being separated or tried by court martial.

MARINE CORPS

General MEAD. The urinalysis program can only identify presence of one of six drugs in a Marine at the time a urine specimen is taken. This process cannot determine impairment, frequency/amount of use, or legality/illegality of presence. Accordingly, on receipt of confirmation of drug presence in a urine sample by a DOD-certified lab, the commanding officer is required to assess the situation and the Marine to determine probability of existence of an offense and appropriate action. Only if the commander fails to confirm a legal justification for the drug presence, may adverse administrative or disciplinary action be taken against the individual.

The Marine Corps directs automatic discharge for officers in light of special trust and confidence and service-unique concerns. Four officers were identified as possessing an illegal drug substance under the urinalysis program this year and

were discharged. Normally enlisted personnel are retained on active duty on the first offense of drug abuse as long as the command believes the Marine is sincerely willing to adapt the Marine Corps standards on this issue.

FOLLOWUP URINALYSIS TESTING

Senator LEVIN. Dr. Johns, your statement points out that individuals who have low quantities of cannabis by-products in their urine may indicate positive on portable testing devices, but negative by laboratory confirmation. Under current DOD policy, such samples must be considered negative.

Is there any requirement that such individuals present themselves for follow-up urinalysis testing over a period of time?

Dr. JOHNS. The requirement referred to is yet another example of the steps we have taken to insure that individuals are not mis-identified. There is no DOD-wide policy that such individuals be required to submit subsequent samples; however, there is nothing to prohibit the Services from establishing such a requirement.

AIR FORCE

General OAKS. Current DOD policy requires two independent methodologies of urine testing to call a sample "positive". The first test, either an enzyme on radioammunoassay procedure screens the samples for possible positives. The confirmatory test is to be either a gas-liquid-chromatograph (GLC) or a gas chromatograph/mass spectrometer (GC/MS). Portable test kits are an enzyme screening procedure and require one of the confirmatory procedures to be "positive". Without the confirmatory test positive, the sample is considered negative. Under such conditions, no follow-up testing over a period of time is considered appropriate for negatives. Because the Air Force has not been using portable test kits, there has been no requirement for follow-up testing in such cases.

COMBATTING ALCOHOL ABUSE

Senator LEVIN. Dr. Johns (and service witnesses), the prepared statements indicate that alcohol abuse is not only increasing in the services, but is a more serious impediment to military preparedness than drug abuse.

Can each of you give some indication of the resources you are using (staff, laboratory costs, dollars) to combat alcohol abuse compared to the resources you are using to combat drug abuse?

Dr. JOHNS. Specific data concerning resources expended to curb drug and alcohol abuse will be provided by the services. The Health Promotion Office, however, devotes an equal amount of effort to the drug and alcohol abuse problem. During fiscal year 1983 the Armed Forces Information Service (AFIS) provided equal amounts of fiscal support to drug and alcohol issues except in the area of centralized film purchases. Since the inventory of films was well stocked with current films on alcohol abuse, AFIS purchased the rights to two drug and no alcohol films during fiscal year 1983.

ARMY

General MITCHELL. The following information describes the resources utilized in fiscal year 1982 to combat drug abuse compared with alcohol abuse. This data represents financial obligations incurred in fiscal year 1982. Since the implementation of the policy authorizing commanders to use breath tests to identify alcohol abusers (April 29, 1983), additional resources are being expended for the purchase of equipment to conduct alcohol breath tests.

[In thousands of dollars]

	Drug	Alcohol
1. Identification of abusers	7,212	0
2. Education	698	2,160
3. Treatment/rehabilitation	5,603	16,559
4. Staff training	521	1,610
5. Evaluation	457	1,425
6. Planning/coordination	3,170	7,905
7. Research	132	0
Total	17,793	29,659

NAVY

Admiral MULLOY. In fiscal year 1983, total costs incurred by the Navy to support the Drug Abuse Program were approximately $42 million, including $24 million to operate the urinalysis laboratories. This compares with $23 million expended to combat alcohol abuse and alcoholism. Overall, approximately 780 workyears were performed by both civilian and military personnel to fight the Navy's successful "War on Drugs." Of this, 222 workyears were performed by 352 personnel assigned to the urinalysis laboratories. This compares with approximately 720 personnel workyears in Alcohol Abuse Program positions. It should be noted that many of these staff positions and even entire program elements serve to combat substance abuse in its broadest sense; thus an exact division of labor and expenses for allocation between "drugs" and "alcohol" is difficult to estimate.

AIR FORCE

General OAKS. Regarding the number of staff in each area, drug and alcohol abuse control activities are incorporated under the auspices of one office at major installations, each major command and at HQ USAF. Therefore the same personnel service both drug and alcohol abuse problems. We currently have 426 personnel assigned worldwide to drug and alcohol abuse control duties. Upon PCS and during other special events such as professional military education our staffs provide combined drug and alcohol abuse education. Much in the way of staff use can also be seen in the number of people in our rehabilitation program. During fiscal year 1982 we had a total of 10,155 persons in our drug program, and 11,778 in our alcohol rehabilitation programs. (These figures include those in rehabilitation carried over from the previous fiscal year). During fiscal year 1982 laboratory costs were approximately $1,236,000. A total program breakout (including laboratory costs) for fiscal year 1982 is $8.5 million for drugs and $28.5 million for alcohol. The alcohol costs include support for residential and local rehabilitation programs made available for Air Force members and their families. These costs support resources at ten residential Alcohol Rehabilitation Centers and also support local out-patient programs at major Air Force installations.

MARINE CORPS

General MEAD. Although dealing with a legal and an illegal substance, the Marine Corps provides for both concerns under a single substance abuse program although there are some deviations in some specific response programs. The basis for this policy decision has been that abuse of either substance impacts on readiness, that symptoms/problems with alcohol abuse are similar to other drug depressants, and that polydrug use has become common. In light of commonality of treatment facilities, training, etc., there is no distinguishable resource use difference in the Marine Corps program except for the urinalysis program. The Marine Corps spent $1,856,000.00 in fiscal year 1982/83 for portable test kits and reagents to support urinalysis; DOD-certified laboratory support is provided by the Navy.

MANDATORY URINALYSIS AND DISCIPLINARY ACTION TAKEN

Senator LEVIN. Mr. Johns, as I understand it, mandatory urinalysis may be ordered by a commanding officer to determine a member's competency for duty. The results of these tests may not be used for disciplinary action, but they may be used to justify administrative actions.

(*a*) Specifically, what is the most severe administrative action which can be taken against a member of the armed services as a result of a positive test under the mandatory urinalysis to determine competency for duty?

(*b*) Does a member have a right to appeal these administrative actions?

(*c*) Is the decision to order a member to take a urinalysis test completely at the discretion of the commander?

(*d*) Should the test come back positive, is the decision to take administrative action left solely to the discretion of the commander?

(*e*) If so, what procedures, if any, have been implemented to protect against possible abuses of discretion by commanding officers?

Dr. JOHNS. (a) The most severe administrative action that a servicemember faces when he or she tests positive on a fitness for duty mandatory urinalysis is a discharge from the service under honorable conditions.

(*b*) All administrative discharge proceedings contain essential due process protections for servicemembers. In addition to the due process protections established by the Department of Defense directives on administrative separations,

the servicemember has a statutory right to appeal discharge determinations to the Service Discharge Review Boards and to the Boards for Correction of Military and Naval Records.

(*c*) Because commanders are held responsible for the performance of their units and the members of their commands, they have been granted authority to direct members to take urinalysis tests in accordance with Department of Defense directives. These directives guide the discretion of commanders and they prescribe the limits on the use of test results.

(*d*) The decision to initiate action based on positive test results rests with the unit commander. Final authority in regard to adverse personnel action almost always rests with higher level authority. Of course, commanders' individual actions are always subject to review and correction by higher authority.

(*e*) (Defer to services.)

ARMY

General MITCHELL. The most severe type of administrative action a commander is authorized to initiate on an individual is separation proceedings. There are a multitude of other administrative options available to a commander in determining how to effectively deal with a specific instance of abuse. These include such things as a letter or verbal reprimand, imposition of a bar to reenlistment, reclassification action and enrollment into the Army's Alcohol and Drug Abuse Prevention and Control Program for rehabilitation. In those type of actions that have an adverse impact on the soldier appeal mechanisms exist whereby the soldier may seek redress. The urinalysis program is a commander's tool in identifying drug abusers. The decision to require a soldier to undergo urinalysis is based on a commander's suspicion of abuse, as part of a search or seizure or as part of a military inspection. Except in those instances where the individual identified is an officer/warrant officer, senior enlisted person or second time offender, the decision as to what type of action to take is a commander's judgment. All soldiers identified as drug abusers must be referred to the ADAPCP for an initial screening to determine the degree of abuse. Those soldiers who feel that inappropriate actions have been initiated against them may appeal their cases to the next higher authority for review.

AIR FORCE

General OAKS. Mandatory urinalysis may be directed as part of an inspection, under authorized search and seizure, as part of command-directed examination to determine competency for duty, in conjunction with a DOD drug treatment and rehabilitation program, in conjunction with a mishap or safety investigation, or any examination ordered by medical personnel for a valid medical purpose. Urinalysis results obtained from commander directed competency for duty test, participation in rehabilitation, or accident investigation may not be used as the basis for disciplinary action under the UCMJ, but may be used in administrative actions. The most severe administrative action which can be taken in these situations is administrative separation with an honorable discharge if the sole basis for discharge is drug abuse as determined from the urinalysis. All members have due process rights of appeal. The commander has the discretion to order urinalysis testing and to determine appropriate action as a result of a positive urinalysis. While the commander makes an independent decision, several professional specialists are available for consultation (i.e. laboratory/medical specialists, attorneys, and personnel experts). While the decision is the commander's, and there may be possible abuses in discretion of authority, all members of the armed services have numerous protections. These include corrections through the chain of command or the Air Force board process. All members are free to seek assistance from legal council at any time. Additionally, there are statutory protections in this area, namely 10 U.S.C. 1034 which provides for direct communication with the Congress, and 10 U.S.C. 938 which provides for redress of grievances.

MARINE CORPS

General MEAD. The results of mandatory urinalysis to determine competency for duty may be the basis of administrative proceedings to separate the servicemember involved. Those results may not, however, be used to characterize service as other than honorable unless the urinalysis was conducted as a valid inspection, was based upon probable cause or constituted an examination conducted for a valid medical reason (other than to determine fitness for duty). Consequently, a servicemember whose drug abuse is detected through such an involuntary urinalysis may thereby be separated from the service, but the type of discharge awarded will not be based on the urinalysis results.

Administrative action is initiated by the servicemember's commander. The administrative procedure established to process these actions provides for independent evaluation and decision by an administrative board of officers and by the cognizant general court-martial convening authority. Thus, the final decision to separate an individual is not left to the discretion of the commander. Similarly, the issue of characterization of discharge (honorable or general under honorable conditions) is independently evaluated at both stages of this administrative process.

An adverse characterization of discharge (under other than honorable conditions) may be awarded only if justified by factors independent of the urinalysis results.

At an administrative discharge board, the servicemember is represented by lawyer council, may present evidence in his/her own behalf, and may cross-examine all witnesses. The servicemember may challenge board members and may make argument to the board members.

MILITARY READINESS AFFECTED BY DRUG AND ALCOHOL ABUSE

Senator LEVIN. (All service witnesses.) Can you specifically state how military readiness is quantitatively affected by drug or alcohol abuse?

Dr. JOHNS. To date the Department of Defense has not conducted formal research on the effects of drug and alcohol abuse on military readiness because the research paradigm that would be required to assess military impairment resulting from such abuse would be extremely complex and expensive to implement.

The effects of drugs and alcohol on military performance would likely vary as a function of:

(1) Type of psychoactive substance,
(2) Specific nature of military task involved,
(3) Degree of skill level by the user,
(4) Complexity of the task,
(5) Drug and alcohol effects on performance in interaction with other likely combat stressors such as noise, overblast, heat, encapsulated environments, fear, etc.

Beyond this it is important to distinguish effects of substances on performance as acute, chronic, or withdrawal.

While drug and alcohol abuse likely impair performance in critical combat skills, such abuse may have more subtle but nevertheless more profound effects such as eroding unit morale and confidence of troops, creating dissension between line troops and their military leaders, and encouraging other antisocial behaviors.

Data on "garrison" effects of drug and alcohol abuse are rarely specifically tracked by the Services. To the extent that such information is available, it will be provided by the service witnesses.

ARMY

General MITCHELL. We are unable to quantify the adverse effects of drug or alcohol abuse on military readiness; however, there are sufficient indicators available to allow us to assess that the impact is great. The recent DOD survey on alcohol and drug abuse shows that 19 percent of those soldiers surveyed reported diminished work performance because of drug abuse. 10 percent of the soldiers surveyed indicated that they had suffered work impairment because of alcohol abuse. During fiscal year 1982 there were 3,565 soldiers separated due to alcohol or drug abuse, this represents a loss of approximately 32.1 million dollars in replacement and training cost. Finally, for the first three quarters of fiscal year 1983, alcohol related Army accidents cost 9.7 million dollars in equipment repair and/or replacement. The Walter Reed Army Institute of Research study on the Impact of Drug Abuse on Tank Crew Cohesion, further substantiates our belief that drug abuse does impact on combat situations. During fiscal year 1982, 125 soldiers were killed as a result of traffic accidents related to drug or alcohol abuse. This is 125 too many. The Army's philosophy of drug and alcohol abuse being incompatible with military service is based on the premise that both adversely impact on our readiness, the morale, welfare, and safety of our soldiers, civilian employees, and family members.

NAVY

Admiral MULLOY. No, we cannot quantitatively demonstrate the correlation between drug or alcohol abuse and military readiness. However, since the beginning of Navy's War on Drugs in February 1982 we have seen no decrement to manning or readiness. During that same time period overall unit operational readiness

was up 10 percent and personnel readiness was up 17 percent. Also, during that same period retention of first, second term and career personnel was up 9.5 percent.

AIR FORCE

General OAKS. While we cannot state the quantitative impact of all drug and alcohol abuse on readiness, we do know its partial impact in a number of different areas. For instance, our alcohol-related motor vehicle mishap experience for CY 1982 resulted in 71 fatalities, 10 disabilities, and 7,746 lost workdays due to hospitalization or confinement to quarters. Government motor vehicle (GMV) cost losses for these alcohol-related mishaps was $168,000, or 8 percent of the total cost for all GMV mishaps. The private motor vehicle (PMV) data cannot be quantified as most AF PMV mishaps occurred off-base and cost data for such mishaps is therefore often unavailable. PMV alcohol-related mishaps did account for 22 percent of the total PMV lost workday cases. Of the 52,000 Air Force personnel on the Personnel Reliability Program, 525 were disqualified for alcohol-abuse reasons and 848 for drug-abuse reasons. Training losses are unavailable for these cases, as some costs are recouped by rehabilitation and full utilization of personnel in other Air Force specialties. Alcohol program discharge losses prior to expiration of term of service (ETS) for fiscal year 1982 resulted in an estimated total training investment loss of $32,635,420 for the 2,235 personnel discharged. At the same time, successful completion of alcohol rehabilitation of 4,867 individuals resuled in an estimated savings of $71,067,934. Drug rehabilitation discharge loss resulted in an estimated training investment loss of $59,690,-919 for the 4,001 personnel discharged prior to ETS for fiscal year 1982. Savings for the same period due to successful completions is estimated at $59,574,983 for the 3,457 successful drug rehabilitation program completions.

Because of the 24 hour duty orientation of the Air Force work environment, which does not account for the military personnel overtime, specific evidence of increases and decreases in labor hours, productivity, training costs other than those mentioned above, and equipment costs are not available.

The Air Force policy of rehabilitating drug and alcohol abusers with potential while discharging those without potential keeps the quantitative as well as qualitative impact of drug and alcohol abuse on Air Force readiness to a minimum.

MARINE CORPS

General MEAD. The Marine Corps currently does not have the means to quantitatively assess abuse impact on readiness. We are aware of deficiencies in this area and are striving to develop indicators and tools to include voluntary disclosure correlationships to drug/alcohol related incidents and unit readiness, if anonymity can be maintained. Additionally, we are developing an automated reporting system to enhance data collection in this area.

MILITARY DRUG TESTING CONSIDERED "SOUND"

Senator LEVIN. Dr. Johns, you state, that both conferences (joint DOD, White House Drug Abuse Policy Office, and the National Institute on Drug Abuse—1982) concluded that the military program of testing was "sound." Please elaborate. Does this mean they concluded that the testing procedures are 100 percent accurate?

Out of this group of experts, did any disagree with the testing results? Who and for what reasons did they disagree?

Dr. JOHNS. As I stated in my answer to the first question, no laboratory procedure can be presumed to be 100 percent accurate 100 percent of the time. It has been the consensus of the scientific authorities who have reviewed our procedures that the procedures, when performed correctly by properly trained personnel under adequate quality control procedures, are scientifically sound. It has been our experience thus far that when errors have occurred, they have been due to human factors, rather than to the scientific adequacy of the procedure. A notable critic of our system (who has been included in the NIDA review of our modified testing protocol) has been Dr. Arthur McBay, Medical Examiner for Chapel Hill, North Carolina. Dr. McBay has expressed a preference for gas chromatography/mass spectrometry as a confirmatory test rather than the gas liquid chromatography procedure currently in use in DOD drug testing laboratories.

Senator HUMPHREY. The subcommittees stand adjourned.

[Whereupon, at 11:35 a.m., the subcommittees adjourned, subject to the call of the Chairs.]

APPENDIX A

Highlights of the 1982 Worldwide Survey of Alcohol and Nonmedical Drug Use Among Military Personnel

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1. INTRODUCTION

In the Armed Forces the misuse of alcohol and the use of drugs for nonmedical purposes are recognized problems that impact on the state of military readiness essential to preserve the national security. Approaches to effective prevention, intervention and treatment, however, cannot be developed and executed without a clear understanding of the nature and extent of these problems. This suggests the need for comprehensive, broad based data about the prevalence of alcohol and nonmedical drug use and the adverse consequences resulting from such use.

A systematic effort to obtain data that can be used to guide and evaluate program policies was begun in 1980 under the direction of the Assistant Secretary of Defense (Health Affairs). A series of recurrent surveys was instituted to study drug and alcohol abuse in the military. Results from these surveys will be used to assess various aspects of the drug and alcohol abuse prevention program, to determine the appropriateness of the emphasis placed on the program elements, to examine the impact of current and future program policies, and to extend knowledge and understanding of drug and alcohol use and problems in the military.

Overview

This report provides highlights of the 1982 Worldwide Survey of alcohol and nonmedical drug use in the military. Additional details of the research which was conducted by the Research Triangle Institute (RTI) are presented in the main report (Bray, Guess, Mason, Hubbard, Smith, Marsden, and Rachal, 1983).

The data were obtained through a survey that was administered to a representative sample of all active duty military personnel below pay grade 07. A two-stage sampling design was used that resulted in the selection of 58 first stage units (installations) and 26,964 sample individuals. Data collection from the four Services was achieved in two phases. At phase I, two-person RTI field teams traveled to 58 major installations and administered surveys in group sessions during a two-day period. At phase II, following the field team visit, the Military Liaison Officer (MLO) at each installation obtained additional questionnaires from personnel selected for the survey who did not participate during phase I.

The focus of the report is on understanding the nature and extent of alcohol and nonmedical drug use and the resulting consequences of that use in the military services. In the remainder of this chapter, the methodology of the study is described. Chapter 2 presents data on the prevalence of alcohol use, and chapter 3 provides data on the prevalence of nonmedical drug use. In chapter 4 negative effects and consequences that result from alcohol and drug use are examined. Comparisons are made in chapter 5 of our current data to those of the military in the 1980 Worldwide Survey and to those of civilians in the general population from a recent national survey. Following this, chapter 6 reports multivariate analyses that examine the joint effects of demographic and psychological/behavioral variables that are important in explaining for alcohol and drug use and the consequences of that use.

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Research Design and Procedures

The methodology of the 1982 Worldwide Survey consisted of a complex array of activities. The present section describes the procedures used to orchestrate the data collection in a representative sample of active duty military personnel below pay grade 07.

Survey Questionnaire. The primary data collection instrument was the survey questionnaire. Using the 1980 questionnaire (Burt and Biegel, 1980) as a foundation, a refined instrument was developed for the 1982 Worldwide Survey. Items in the questionnaire were arrayed into several broad areas. The most basic information asked about respondents' use of alcohol and non-medical drugs during 30 day and 12 month periods. Consequences of use, along with measures of work impairment and dependence were included. Reports of attitudes and behaviors of theoretical and applied interest were asked. Reasons for use and nonuse also were obtained along with information about the context of use. Finally, basic demographic indicators were included as were questions about alcohol and drug treatment.

Sampling Design. The sampling design for the 1982 Worldwide Survey can be summarized as a deeply stratified, two stage design. First stage sampling units were constructed by combining Service level organizational units that were geographically proximal. These organizational units for the Services were: Army--Army Location Code (ARLOC); Navy--Unit Identification Code (UIC); Marine Corps--Monitor Command Codes (MCC) and Reporting Unit Codes (RUC); and Air Force--Consolidated Base Personnel Office (CBPO).

The first stage sampling frame was stratified by Service (Army, Navy, Marine Corps, Air Force) within four broadly stratified geographic regions of the world. The geographic regions and the areas they encompassed were:

- Americas -- Alaska, Canada, Continental United States (CONUS), Greenland, Iceland, Antigua, Bermuda, Cuba, Diego Garcia, Panama, Puerto Rico
- North Pacific -- Republic of Korea, mainland Japan, Okinawa
- Other Pacific -- Australia, Canton Enderbury, Gilbert Ellice, Guam, Hawaii, Johnston Atoll, Midway, Pacific Trust, Philippines, Wake
- Europe -- Belgium, West Germany, Greece, Italy, Netherlands, Portugal, Spain, Turkey, United Kingdom

A total of fifteen first stage strata were defined (one for each Service in each region except for Marines in Europe which were sampled in conjunction with the Navy in Europe). The first stage sample was selected with probability proportional to size and with minimum replacement. Composite size measures were constructed to provide an equal probability selection of personnel within each pay grade grouping within each of the first stage strata.

Second stage sampling units were lines on the personnel rosters of the organizational units selected at the first stage of sampling. The second stage frame was stratified into five pay grade groups (E1-E5's, E6-E9's, W1-W4's, O1-O3's, and O4-O6's) within each first stage unit, except for the Air Force which does not have warrant officer grades. The second stage sample was selected with equal probability and without replacement from within second stage strata.

Table 1 shows the distribution of the first stage sampling units, and the first and second stage sample sizes for the 1982 Worldwide Survey. Installations selected for the sample were located in the following countries for each region.

- Americas -- CONUS
- North Pacific -- Republic of Korea, mainland Japan, Okinawa
- Other Pacific -- Hawaii, Republic of the Philippines, Guam
- Europe -- West Germany, Italy, Greece, United Kingdom

Demographic characteristics of the sample and Total DoD appear in Table 2. As shown, the sample generally provides a good representation of the military on the characteristics that are displayed. Educational background of the sample varied most notably from that of the DoD population. The major discrepancy was that people in the sample indicated a somewhat higher level of educational training (particularly those beyond high school with no formal degree) than that reported by official DoD records of educational attainment. This difference is probably explained by the way the educational data are gathered. DoD asked for highest year of school completed. The survey asked respondents to indicate whether they had some college, but not a four year degree. Thus, survey respondents who attended college for one term but did not complete the year were counted in the survey as beyond high school, but by DoD as having a high school education.

Field Procedures. Detailed field procedures were developed to collect questionnaire data from the personnel selected to participate in the study. Coordination of survey activities among participating installations was achieved by the appointment of a Headquarters Liaison Officer (HLO) in Washington for each Service and a Military Liaison Officer (MLO) at each participating installation.

Data collection was conducted in two phases. During Phase I (September through November, 1982), MLOs were sent lists of personnel that had been selected to participate in the survey at their installations. MLOs planned and coordinated two-day, in-person visits by RTI field teams who administered questionnaires in group sessions. Participants' responses were given anonymously.

Phase II data collection (September through January, 1983) consisted of MLOs obtaining completed survey questionnaires from personnel who did not attend any scheduled session during the on-site visit. They did this by conducting sessions with personnel at their installation (using procedures

Table 1. Allocation of the Sample

Region	Service	First Stage Sampling Units	First Stage Sample Size	Second Stage Sample Size
Americas	Army	98	7	3081
	Navy	78	6	3230
	Marine Corps	39	2	859
	Air Force	92	6	2711
	Total	307	21	9881
North Pacific	Army	19	4	1716
	Navy	3	2	1101
	Marine Corps	3	3	1245
	Air Force	5	3	1397
	Total	30	12	5459
Other Pacific	Army	4	2	789
	Navy	8	5	2568
	Marine Corps	3	2	821
	Air Force	3	2	909
	Total	18	11	5087
Europe	Army	92	9	4071
	Navy	6	2	1023
	Marine Corps[a]	0	0	63
	Air Force	22	3	1380
	Total	120	14	6537
Total Worldwide	Army	213	22	9657
	Navy	95	15	7922
	Marine Corps	45	7	2988
	Air Force	122	14	6397
	Total	475	58	26,964

[a]Marine Corps personnel in Europe were classified into Navy first stage units.

Table 2. Selected Demographic Characteristics of Survey Respondents and Total DoD Personnel

Characteristics	Service									
	Army		Navy		Marine Corps		Air Force		Total DoD	
	Sample	Population	Sample	Population	Sample	Population	Sample	Population	Sample	Population
Sex										
Male	88.0	90.4	94.3	92.0	96.1	95.6	88.9	88.8	90.6	90.9
Female	12.0	9.6	5.7	8.0	3.9	4.4	11.1	11.1	9.4	9.1
Race/Ethnicity										
White	60.9	63.0	77.6	80.0	72.5	73.5	78.2	78.2	71.2	72.7
Black	24.6	29.3	10.6	11.4	14.5	19.6	12.8	14.8	16.7	19.7
Hispanic	9.1	4.0	5.5	2.9	9.1	4.5	4.8	3.6	6.9	3.6
Other	5.4	3.7	6.3	5.6	3.9	2.4	4.1	3.4	5.2	4.0
Education										
Less than high school	5.2	9.2	4.3	9.0	5.0	8.2	0.7	0.9	3.7	6.8
High School Grad/GED	51.1	67.8	56.3	70.3	58.0	77.3	33.6	64.6	48.2	68.4
Beyond HS, No Degree	30.1	10.0	29.2	9.4	27.4	5.7	42.5	15.5	33.1	11.0
College Degree or Beyond	13.6	13.0	10.2	11.3	9.7	8.8	23.2	19.0	15.0	13.8
Age										
17-20	23.3	20.9	31.0	21.1	30.8	32.4	12.3	15.6	23.0	20.6
21-24	31.6	30.1	29.5	31.2	39.6	35.1	27.6	27.7	30.6	30.2
25-30	25.2	24.8	19.6	26.3	18.3	18.9	25.5	24.8	23.2	23.9
31 or older	20.0	24.2	19.9	21.4	11.3	13.6	34.6	31.9	23.2	25.3
Marital Status										
Not married	49.6	47.4	59.0	54.1	57.1	60.7	36.4	38.0	49.1	47.8
Married	50.4	52.6	41.0	45.9	42.9	39.3	63.6	61.9	50.9	52.2
Pay Grade										
E1-E5	70.7	67.4	74.0	68.2	78.5	75.8	61.8	64.5	69.8	67.5
E6-E9	17.4	19.3	17.5	19.7	12.9	14.5	18.3	17.9	17.2	18.6
W1-W4	2.2	1.9	0.4	0.5	0.6	0.8	*	*	1.0	0.9
O1-O3	7.3	7.3	5.3	7.1	6.1	6.3	12.3	11.3	8.1	8.3
O4-O6	2.4	4.1	2.8	4.5	1.9	2.6	7.7	6.3	3.9	4.7
Total Personnel	33.6	36.7	28.9	26.3	10.9	9.3	26.5	27.6	-	-

Note: Tabled values are column percentages. Population data for December 1982 for all DoD personnel were provided by the Defense Manpower Data Center.

*Not applicable.

that preserved the respondents' anonymity) or by mailing questionnaires to individuals no longer present.

Usable questionnaires were obtained from 21,936 personnel for an overall response rate of 84.3 percent. The response rate for each Service was Army -- 80.0 percent; Navy -- 83.4 percent; Marine Corps -- 83.1 percent; and Air Force -- 92.6 percent.*

Table 3 displays the distribution of survey respondents across the stratification variables of Service, region, and pay grade. Many tables of the report present data in the form or some slight variation of the pattern shown in Table 3. Because of the large number of different sample n's, they are not presented in the individual tables of the analyses. It will be necessary to refer to this table to determine the sample sizes used.

Standard Errors. Most of the tables that follow present two numbers in each cell. The first number is an estimate of the proportion of the population with the characteristics that define the cell. The second number, in parentheses, is the standard error of the estimate. Standard errors represent the degree of variation associated with taking observations on a sample rather than on every member of the population. Confidence intervals, or ranges that are very likely to include the true population value, can be constructed using the standard errors. The 95 percent confidence interval is computed by adding to and subtracting from the estimated proportion the result of multiplying 1.96 times the standard error for that cell. (Obviously, for very small or very large estimates, the respective smallest or largest value in the confidence interval range will be zero or 100 percent.) The interpretation of the confidence interval range is that, if the study were to be repeated with 100 identically-drawn samples, 95 of the sample estimates would fall within the confidence interval range; thus, we are 95 percent certain that the true population value also lies within that range. Clearly, for a given confidence level (e.g., 95 percent), smaller standard errors indicate that the cell proportions estimate the true population value more precisely and larger standard errors indicate that the true population value is estimated less precisely. In tables where standard errors do not appear, a reasonable rule-of-thumb is that the sampling error associated with any point estimate is equal to or slightly larger than the standard error presented with an equal-sized estimated proportion in table cells defined by similar characteristics (i.e., service, pay grade, etc.). A more detailed explanation of sampling errors appears in the main report (Bray et al., 1983).

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*A complete discussion of response rate computations appears in the main report (Bray et al., 1983). Response rate was computed in a different manner than in the 1980 survey by Burt and Biegel (1980). The rate analogous to the 1980 "Response Rate" was termed a completion rate. The respective values for the 1980 and 1982 surveys were: Army -- 91%, 94%; Navy -- 95%, 98%; Marine Corps -- 91%, 97%; Air Force -- 96%, 99%; and Total DoD -- 93%, 97%.

Table 3. Distribution of 1982 Worldwide Survey Respondents

Region/Pay Grade	Service				Total DoD
	Army	Navy	Marine Corps	Air Force	
Americas					
E1-E5	1363	1826	472	1487	5148
E6-E9	437	464	83	434	1418
W1-W4	57	11	2	*	70
O1-O3	202	105	41	330	678
O4-O6	63	61	10	202	336
Total	2122	2467	608	2453	7650
North Pacific					
E1-E5	998	666	749	923	3336
E6-E9	271	192	165	244	872
W1-W4	31	6	5	*	42
O1-O3	92	59	48	76	275
O4-O6	36	37	19	41	133
Total	1428	960	986	1284	4658
Other Pacific					
E1-E5	392	1280	627	527	2826
E6-E9	133	551	72	192	948
W1-W4	12	11	1	*	24
O1-O3	22	116	33	78	249
O4-O6	32	101	7	65	205
Total	591	2059	740	862	4252
Europe					
E1-E5	2459	477	36	829	3801
E6-E9	564	230	8	251	1053
W1-W4	31	6	1	*	38
O1-O3	151	55	5	88	299
O4-O6	34	95	5	51	185
Total	3239	863	55	1219	5376
Total Worldwide					
E1-E5	5212	4249	1884	3766	15111
E6-E9	1405	1437	328	1121	4291
W1-W4	131	34	9	*	174
O1-O3	467	335	127	572	1501
O4-O6	165	294	41	359	859
Total	7380	6349	2389	5818	21936

Note: Table entries are numbers of respondents who completed a usable questionnaire.

*Not applicable.

2. PREVALENCE OF ALCOHOL USE

Military personnel in the four Services around the world consume considerable amounts of beer, wine, and hard liquor. This chapter reports past and current use of these three alcoholic beverages. For each beverage, respondents were asked to report for the past 30 days: 1) the number of days they drank that beverage, 2) the size of the usual drink, and 3) the number of drinks consumed on a typical day when they drank the beverage. In addition they were also asked to report for the past 12 months the number of days per week or month they typically consumed 8 or more drinks of each type beverage in a single day.

From these items, measures of alcohol use were constructed that included frequency and quantity of beverage use including primary beverage (i.e., the beverage consumed most often during the past 30 days); a quantity/frequency index of average daily ounces of ethanol; and a typology of drinking levels.

Alcohol Use During the Past 30 Days

- The use of alcohol among military personnel is almost universal (Table 4). Of all military personnel, 77 percent drank beer, 38 percent drank wine and 53 percent drank hard liquor during the past 30 days. Overall, 84 percent of all military personnel drank their "primary beverage" during the past 30 days.

- The use of alcoholic beverages is highest among 04-06 personnel (Table 4). Levels of use range from 69 percent for hard liquor (compared to 47 to 57 percent for other pay grades), 80 percent for wine (versus 31 to 63 percent), 81 percent for beer (versus 69 to 78 percent); and 91 percent primary beverage (versus 83 to 90 percent).

- Few differences exist in the proportion of drinkers across regions. The highest is the Other Pacific (89 percent) and Europe (89 percent), followed by the North Pacific (86 percent) and the Americas (83 percent).

- Nearly all military personnel drink alcoholic beverages, but the frequency with which they drink is generally low (Table 5). For Total DoD, 32 percent consumed their primary beverage 1-3 days a month and 26 percent 4-10 days a month.

- The frequent use of primary beverage 20-30 days a month (Table 5) occurs more often among 04-06's (20 percent) than among E1-E5's (13 percent), E6-E9's (11 percent) or 01-03's (8 percent).

- The modal quantity of any type of alcohol consumed in a typical drinking day is low, 2-3 drinks, and is the same for all Services and pay grades (Tables 6-8).

Table 4. Alcoholic Beverage Use During the Past 30 Days

Beverage/Pay Grade	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
Beer										
E1-E5	80.8	(1.4)	74.2	(3.6)	80.5	(1.2)	75.6	(1.1)	77.6	(1.2)
E6-E9	75.7	(1.8)	73.5	(1.8)	75.2	(1.7)	74.3	(2.4)	74.6	(1.1)
W1-W4	66.6	(4.2)	74.5	(18.0)	+	(+)	*	(*)	69.1	(3.9)
01-03	79.7	(1.9)	73.2	(7.3)	82.8	(1.8)	78.2	(1.3)	78.1	(1.5)
04-06	78.9	(4.5)	86.6	(3.4)	90.7	(4.2)	79.2	(2.5)	81.0	(1.7)
Total	79.5	(0.8)	74.3	(3.0)	80.3	(1.0)	76.0	(0.6)	77.2	(0.9)
Wine										
E1-E5	38.0	(2.5)	28.3	(3.3)	31.8	(2.4)	39.5	(1.5)	35.0	(1.5)
E6-E9	30.4	(3.9)	26.6	(1.3)	28.4	(2.0)	36.1	(2.4)	30.9	(1.7)
W1-W4	40.8	(5.6)	40.4	(21.5)	+	(+)	*	(*)	39.0	(5.0)
01-03	58.6	(3.7)	67.6	(5.5)	50.8	(6.0)	67.2	(2.9)	63.3	(2.1)
04-06	78.5	(2.4)	84.0	(6.3)	85.3	(8.8)	78.4	(1.6)	79.8	(1.5)
Total	39.2	(2.7)	31.7	(3.0)	33.4	(2.4)	45.3	(1.6)	38.4	(1.4)
Hard Liquor										
E1-E5	53.6	(2.2)	56.0	(2.8)	52.8	(1.2)	51.8	(1.9)	53.7	(1.2)
E6-E9	47.0	(1.7)	47.7	(1.4)	34.0	(3.8)	48.3	(2.6)	46.7	(1.1)
W1-W4	46.0	(8.6)	52.3	(15.3)	+	(+)	*	(*)	47.0	(7.6)
01-03	56.6	(3.6)	58.4	(5.4)	49.5	(1.1)	58.6	(1.9)	57.3	(1.7)
04-06	60.9	(6.7)	70.2	(5.1)	57.6	(23.0)	72.0	(1.9)	68.6	(2.3)
Total	52.7	(1.8)	55.0	(2.2)	50.3	(0.6)	53.5	(1.2)	53.3	(0.9)
Primary Beverage										
E1-E5	86.7	(0.8)	79.6	(3.8)	82.6	(1.3)	84.7	(1.3)	83.8	(1.2)
E6-E9	83.3	(1.6)	81.0	(1.1)	82.1	(3.4)	84.9	(1.8)	83.1	(0.9)
W1-W4	82.1	(5.3)	78.5	(17.6)	+	(+)	*	(*)	82.7	(4.7)
01-03	89.6	(1.2)	88.6	(2.5)	83.9	(2.2)	90.8	(1.6)	89.6	(1.0)
04-06	91.9	(2.9)	94.2	(3.2)	99.5	(0.5)	89.6	(1.8)	91.4	(1.2)
Total	86.3	(0.5)	80.8	(3.0)	83.1	(1.4)	85.9	(0.9)	84.4	(0.9)

Note: Tabled values are percentages and represent prevalence estimates with standard errors in parentheses. Some individuals prefer the term "prevalence rate" when referring to percentages and the term "prevalence" when referring to frequencies of an event. That distinction is not made in the present report. Generally the term "prevalence" has been used when referring to percentages. The category of "Primary Beverage" represents the beverage (beer, wine, or hard liquor) each individual reported using most often during the past 30 days.

* Not applicable.

+Fewer than 20 respondents.

Table 5. Frequency of Use of Primary Beverage During the Past 30 Days

Pay Grade/Days of Use	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
E1-E5										
None	13.3	(0.8)	20.4	(3.8)	17.4	(1.3)	15.3	(1.3)	16.2	(1.2)
1-3 days	31.3	(1.5)	29.0	(1.3)	26.2	(1.4)	32.6	(0.8)	30.5	(0.7)
4-10 days	24.2	(0.9)	23.1	(1.2)	28.8	(0.5)	27.8	(0.7)	25.2	(0.5)
11-19 days	16.2	(0.7)	14.2	(1.6)	17.1	(1.0)	14.3	(0.9)	15.3	(0.6)
20-30 days	15.0	(0.9)	13.3	(2.1)	10.5	(0.9)	10.0	(1.0)	12.8	(0.7)
E6-E9										
None	16.7	(1.6)	19.0	(1.1)	17.9	(3.4)	15.1	(1.8)	16.9	(0.9)
1-3 days	34.1	(1.9)	38.6	(3.2)	33.7	(1.9)	37.3	(1.3)	36.2	(1.2)
4-10 days	26.6	(2.2)	23.7	(1.6)	21.7	(0.7)	25.1	(1.2)	25.0	(1.0)
11-19 days	10.9	(0.9)	10.8	(0.7)	10.4	(0.4)	12.0	(1.8)	11.1	(0.7)
20-30 days	11.8	(1.6)	7.9	(1.0)	16.3	(1.5)	10.6	(1.3)	10.7	(0.8)
W1-W4[a]										
None	17.9	(5.3)	21.5	(17.6)	+	(+)	*	(*)	17.3	(4.7)
1-3 days	40.0	(7.4)	23.3	(11.2)	+	(+)	*	(*)	38.8	(7.1)
4-10 days	19.8	(2.9)	37.7	(24.8)	+	(+)	*	(*)	23.0	(4.2)
11-19 days	11.8	(7.2)	15.4	(10.4)	+	(+)	*	(*)	11.6	(6.1)
20-30 days	10.5	(2.5)	2.2	(1.7)	+	(+)	*	(*)	9.3	(2.2)
O1-O3										
None	10.4	(1.2)	11.4	(2.5)	16.1	(2.2)	9.2	(1.6)	10.4	(1.0)
1-3 days	32.3	(3.7)	31.7	(4.9)	33.1	(7.5)	39.3	(2.6)	35.2	(2.1)
4-10 days	32.7	(4.1)	37.4	(4.3)	28.9	(6.5)	31.8	(2.6)	32.9	(2.0)
11-19 days	14.5	(2.3)	16.2	(3.4)	15.7	(2.3)	12.3	(1.2)	14.0	(1.1)
20-30 days	10.2	(1.4)	3.2	(2.0)	6.2	(3.4)	7.4	(2.1)	7.5	(1.2)
O4-O6										
None	8.1	(2.9)	5.8	(3.2)	0.5	(0.5)	10.4	(1.8)	8.6	(1.2)
1-3 days	25.5	(3.9)	25.8	(3.5)	24.4	(12.5)	26.6	(2.8)	26.1	(2.0)
4-10 days	28.5	(4.3)	35.4	(3.9)	28.0	(11.6)	24.5	(0.6)	27.6	(1.4)
11-19 days	13.0	(3.3)	17.1	(4.9)	21.0	(11.4)	20.1	(2.1)	18.0	(1.6)
20-30 days	24.9	(4.0)	15.9	(3.8)	26.0	(12.8)	18.5	(3.0)	19.7	(2.1)
Total										
None	13.7	(0.5)	19.2	(3.0)	16.9	(1.4)	14.1	(0.9)	15.6	(0.9)
1-3 days	31.9	(1.3)	30.7	(1.6)	27.7	(1.1)	33.8	(0.7)	31.7	(0.7)
4-10 days	25.2	(0.9)	24.4	(0.8)	28.0	(0.8)	27.6	(0.2)	25.9	(0.4)
11-19 days	15.0	(0.7)	13.8	(1.4)	16.1	(0.7)	14.1	(0.7)	14.5	(0.5)
20-30 days	14.2	(0.5)	11.8	(1.7)	11.2	(0.9)	10.5	(0.8)	12.3	(0.6)

Note: Tabled values are percentages and represent prevalence estimates with standard errors in parentheses. The term "Primary Beverage" represents the beverage (beer, wine, hard liquor) that respondents reported using most often.

*Not applicable.

+Fewer than 20 respondents.

[a]Estimates of use for Navy warrant officers are accompanied by rather large standard errors indicating the data have low reliability and should be interpreted with caution.

- For all beverages (Tables 6-8) heavy consumption, 8 or more drinks on a typical drinking day during the past 30 days, occurs most often among E1-E5 personnel (16 percent beer, 2 percent wine, 8 percent hard liquor). For E6-E9's, 01-03's and 04-06's, it occurs substantially less often (1-5 percent beer, 0-1 percent wine, 0-3 percent hard liquor).

Frequency of Heavy Drinking

- Frequent heavy drinking (the rate that 8 or more drinks per day were consumed during the past 12 months) of beer is more common than similar consumption of hard liquor or wine. Across all pay grades frequent heavy drinking, on 3 or more days a week, ranges from 11 percent for beer to 4 percent for hard liquor and 1 percent for wine.

- Frequent heavy drinking of all beverages occurs most often among E1-E5's. Consumption of 8 or more drinks on 3 or more days a week was reported by 15 percent of the respondents for beer, by 2 percent for wine, and by 5 percent for hard liquor (Table 9).

Quantity/Frequency Classifications

- The combined quantity and frequency of alcohol use is represented by two measures: the average daily ounces of ethanol consumed and the typology of drinking levels (abstainer, infrequent-light, moderate, moderate-heavy, heavy).

- The average daily consumption of ethanol tends to be low (Table 10). For Total DoD, 78 percent consume less than 2 ounces of ethanol a day on the average.

- Heavy ethanol consumption of 5 or more ounces per day occurs for 7 percent of all personnel (Table 10). Among pay grades it is most likely among E1-E5 personnel (9 percent). Among Services it is most likely in the Army and Navy (8-9 percent).

- The classification of personnel by drinking levels shows the modal category to be moderate drinkers, followed by moderate-heavy (Table 11). Thirty percent of DoD personnel are moderate drinkers (drink about once a week and small to moderate amounts per occasion), and 26 percent are moderate-heavy drinkers (drink at least once a week and medium to large amounts per occasion).

- The drinking level typology defines 14 percent of personnel as heavy drinkers (Table 11). Among pay grades 18 percent of E1-E5's are heavy drinkers compared with 3 to 8 percent of other pay grades. Among the Services, the Army, Navy, and Marine Corps have more heavy drinkers (each 16 percent) than the Air Force (10 percent).

Table 6. Quantity of Beer Consumed on a Typical Drinking Day During the Past 30 Days

Pay Grade/Number of Drinks[a]	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
E1-E5										
None	19.2	(1.4)	25.8	(3.6)	19.5	(1.2)	24.4	(1.1)	22.4	(1.2)
1 Drink	9.0	(0.8)	4.9	(0.5)	6.2	(0.3)	10.3	(0.7)	7.9	(0.4)
2-3 Drinks	29.3	(0.7)	22.6	(1.2)	23.7	(0.7)	31.5	(0.8)	27.4	(0.5)
4-7 Drinks	25.7	(1.0)	26.4	(1.2)	28.8	(0.8)	25.0	(0.9)	26.0	(0.6)
8-11 Drinks	9.5	(0.9)	11.4	(0.9)	13.3	(0.8)	5.6	(0.5)	9.5	(0.4)
12 or more	7.3	(1.0)	8.9	(1.1)	8.5	(0.9)	3.2	(0.4)	6.9	(0.5)
E6-E9										
None	24.3	(1.8)	26.5	(1.8)	24.8	(1.7)	25.7	(2.4)	25.4	(1.1)
1 Drink	13.2	(1.4)	11.5	(0.8)	6.7	(3.0)	14.8	(1.4)	12.8	(0.7)
2-3 Drinks	37.5	(1.3)	31.6	(1.8)	36.4	(0.6)	37.1	(1.3)	35.7	(0.8)
4-7 Drinks	20.0	(0.8)	23.8	(0.8)	28.3	(5.0)	18.2	(2.1)	21.0	(0.8)
8-11 Drinks	3.5	(0.5)	4.5	(0.7)	3.3	(0.5)	3.1	(0.5)	3.6	(0.3)
12 or more	1.5	(0.5)	2.1	(0.7)	0.5	(0.2)	1.2	(0.5)	1.5	(0.3)
W1-W4[b]										
None	33.4	(4.2)	25.5	(18.0)	+	(+)	*	(*)	30.9	(3.9)
1 Drink	14.2	(3.9)	3.1	(2.2)	+	(+)	*	(*)	12.5	(3.2)
2-3 Drinks	35.2	(4.0)	32.8	(20.5)	+	(+)	*	(*)	35.8	(4.4)
4-7 Drinks	16.7	(3.0)	37.7	(24.9)	+	(+)	*	(*)	20.1	(4.4)
8-11 Drinks	0.5	(0.3)	0.0	(**)	+	(+)	*	(*)	0.6	(0.3)
12 or more	0.0	(**)	1.0	(1.0)	+	(+)	*	(*)	0.1	(0.1)
O1-O3										
None	20.3	(1.9)	26.8	(7.3)	17.2	(1.8)	21.8	(1.3)	21.9	(1.5)
1 Drink	20.8	(2.4)	13.3	(2.5)	9.3	(3.9)	25.9	(2.6)	20.9	(1.4)
2-3 Drinks	41.9	(3.0)	39.2	(5.9)	56.2	(2.5)	42.4	(1.6)	42.6	(1.6)
4-7 Drinks	13.9	(3.3)	17.0	(3.2)	16.6	(2.8)	9.1	(1.2)	12.6	(1.5)
8-11 Drinks	2.4	(1.0)	2.8	(1.3)	0.3	(0.1)	0.8	(0.4)	1.7	(0.4)
12 or more	0.8	(0.4)	0.9	(0.7)	0.4	(0.3)	0.0	(**)	0.4	(0.2)
O4-O6										
None	21.1	(4.5)	13.4	(3.4)	9.3	(4.2)	20.8	(2.5)	19.0	(1.7)
1 Drink	25.0	(1.9)	22.6	(4.1)	17.8	(8.4)	27.6	(4.3)	25.6	(2.7)
2-3 Drinks	41.9	(6.8)	57.4	(4.4)	64.1	(16.0)	46.7	(3.3)	48.4	(2.5)
4-7 Drinks	8.4	(2.6)	6.5	(1.7)	8.8	(4.2)	4.5	(1.5)	5.9	(1.1)
8-11 Drinks	3.3	(1.6)	0.0	(**)	0.0	(**)	0.4	(0.4)	0.9	(0.4)
12 or more	0.3	(0.3)	0.1	(0.1)	0.0	(**)	0.1	(0.1)	0.1	(0.1)
Total										
None	20.5	(0.8)	25.7	(3.0)	19.7	(1.0)	24.0	(0.6)	22.8	(0.9)
1 Drink	11.1	(0.6)	7.0	(0.6)	6.7	(0.2)	14.4	(1.1)	10.5	(0.4)
2-3 Drinks	32.1	(0.7)	26.0	(1.4)	28.3	(1.0)	35.0	(0.6)	30.9	(0.5)
4-7 Drinks	23.2	(0.8)	24.9	(1.1)	27.7	(1.0)	20.2	(1.1)	23.2	(0.5)
8-11 Drinks	7.6	(0.7)	9.4	(0.8)	10.9	(0.2)	4.1	(0.5)	7.4	(0.4)
12 or more	5.5	(0.7)	7.0	(1.0)	6.7	(1.1)	2.2	(0.3)	5.1	(0.4)

Note: Tabled values are percentages and represent prevalence estimates with standard errors in parentheses.

[a]A drink is defined as one beer.

[b]Estimates of use for Navy warrant officers are accompanied by rather large standard errors indicating the data have low reliability and should be interpreted with caution.

*Not applicable.

**Informative standard error not available.

+Fewer than 20 respondents.

Table 7. Quantity of Wine Consumed on a Typical Drinking Day During the Past 30 Days

Pay Grade/ Number of Drinks[a]	Service									
	Army		Navy		Marine Corps		Air Force		Total DoD	
E1-E5										
None	61.9	(2.5)	71.7	(3.3)	68.2	(2.4)	60.5	(1.5)	65.0	(1.5)
1 Drink	8.7	(0.7)	6.2	(0.9)	6.3	(1.7)	9.2	(0.5)	7.9	(0.5)
2-3 Drinks	18.6	(1.6)	14.7	(2.1)	15.1	(0.3)	21.8	(0.9)	17.9	(0.9)
4-7 Drinks	7.7	(0.6)	5.5	(0.8)	8.0	(1.3)	7.1	(0.5)	7.0	(0.4)
8-11 Drinks	1.3	(0.2)	0.8	(0.2)	1.3	(0.1)	0.6	(0.2)	1.0	(0.1)
12 or more	1.6	(0.2)	1.1	(0.2)	1.2	(0.4)	0.9	(0.3)	1.3	(0.1)
E6-E9										
None	69.6	(3.9)	73.4	(1.3)	71.6	(2.0)	63.9	(2.4)	69.1	(1.7)
1 Drink	7.9	(1.0)	8.9	(0.6)	10.4	(1.3)	12.8	(1.7)	9.8	(0.7)
2-3 Drinks	17.9	(2.8)	13.6	(1.0)	15.9	(4.3)	18.9	(1.3)	16.9	(1.2)
4-7 Drinks	3.7	(0.4)	3.4	(0.6)	1.9	(1.0)	3.3	(0.5)	3.4	(0.3)
8-11 Drinks	0.4	(0.2)	0.2	(0.2)	0.0	(**)	0.8	(0.4)	0.5	(0.2)
12 or more	0.6	(0.3)	0.5	(0.3)	0.2	(0.1)	0.2	(0.2)	0.5	(0.2)
W1-W4[b]										
None	59.2	(5.6)	59.6	(21.5)	+	(+)	*	(*)	61.0	(5.0)
1 Drink	16.7	(2.9	16.9	(10.8)	+	(+)	*	(*)	15.8	(2.6)
2-3 Drinks	21.6	(3.4)	21.4	(10.8)	+	(+)	*	(*)	20.8	(2.1)
4-7 Drinks	2.5	(1.4)	2.2	(1.7)	+	(+)	*	(*)	2.3	(1.2)
8-11 Drinks	0.0	(**)	0.0	(**)	+	(+)	*	(*)	0.0	(**)
12 or more	0.0	(**)	0.0	(**)	+	(+)	*	(*)	0.0	(**)
O1-O3										
None	41.4	(3.7)	32.4	(5.5)	49.2	(6.0)	32.8	(2.9)	36.7	(2.1)
1 Drink	16.6	(1.7)	26.1	(1.4)	9.5	(2.8)	21.9	(2.1)	20.1	(1.2)
2-3 Drinks	36.9	(3.1)	32.3	(3.0)	29.1	(1.9)	41.6	(2.3)	37.5	(1.5)
4-7 Drinks	4.9	(1.3)	8.1	(2.8)	12.3	(4.8)	3.8	(1.2)	5.5	(0.9)
8-11 Drinks	0.1	(0.1)	1.1	(0.7)	0.0	(**)	0.0	(**)	0.2	(0.2)
12 or more	0.1	(0.1)	0.0	(**)	0.0	(**)	0.0	(**)	0.0	(**)
O4-O6										
None	21.5	(2.4)	16.0	(6.3)	14.7	(8.8)	21.6	(1.6)	20.2	(1.5)
1 Drink	29.3	(3.0)	14.9	(5.8)	18.9	(17.0)	19.1	(2.4)	20.8	(2.0)
2-3 Drinks	43.6	(3.8)	63.8	(4.9)	62.2	(9.5)	56.	(2.6)	55.1	(1.9)
4-7 Drinks	3.9	(1.8)	5.3	(1.9)	4.2	(3.0)	2.6	(0.8)	3.5	(0.7)
8-11 Drinks	1.7	(1.2)	0.0	(**)	0.0	(**)	0.0	(**)	0.4	(0.3)
12 or more	0.0	(**)	0.0	(**)	0.0	(**)	0.1	(0.1)	0.0	(**)
Total										
None	60.7	(2.7)	68.3	(3.0)	66.6	(2.4)	54.7	(1.5)	61.6	(1.4)
1 Drink	9.8	(0.7)	8.0	(0.9)	7.2	(0.8)	12.2	(.9)	9.8	(0.4)
2-3 Drinks	20.5	(2.0)	16.8	(1.9)	16.9	(1.4)	26.3	(.0)	20.8	(0.9)
4-7 Drinks	6.6	(0.5)	5.3	(0.7)	7.3	(0.6)	5.6	(0.5)	6.0	(0.3)
8-11 Drinks	1.1	(0.1)	0.7	(0.2)	1.0	(0.1)	0.5	( )	0.8	( )
12 or more	1.3	(0.1)	0.9	(0.2)	1.0	(0.3)	0.6	(0.2)	1.0	(0.1)

Note: Tabled values are percentages and represent prevalence estimates with standard errors in parentheses.

[a]A drink is defined as one glass of wine.

[b]Estimates of use for Navy warrant officers are accompanied by rather large standard errors indicating the data have low reliability and should be interpreted with caution.

*Not applicable.

**Informative standard error not available.

+Fewer than 20 respondents.

Table 8. Quantity of Hard Liquor Consumed on a Typical Drinking Day During the Past 30 Days

Pay Grade/ Number of Drinks	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
E1-E5										
None	46.4	(2.2)	44.0	(2.8)	47.2	(1.2)	48.2	(1.9)	46.3	(1.2)
1 Drink	7.9	(0.8)	7.2	(0.7)	9.5	(0.9)	8.7	(0.7)	8.0	(0.4)
2-3 Drinks	20.5	(1.2)	19.0	(1.2)	17.4	(0.8)	22.6	(1.3)	20.3	(0.6)
4-7 Drinks	16.4	(0.7)	18.7	(1.3)	17.4	(1.3)	16.2	(1.5)	17.1	(0.6)
8-11 Drinks	5.4	(0.6)	7.3	(0.2)	5.4	(0.4)	2.9	(0.4)	5.3	(0.2)
12 or more	3.4	(0.4)	3.8	(0.4)	3.1	(0.2)	1.3	(0.2)	3.0	(0.2)
E6-E9										
None	53.0	(1.7)	52.3	(1.4)	66.0	(3.8)	51.7	(2.6)	53.3	(1.1)
1 Drink	7.9	(0.9)	7.4	(0.5)	6.3	(1.1)	9.1	(0.6)	8.0	(0.4)
2-3 Drinks	23.6	(1.5)	22.3	(1.9)	18.4	(3.3)	25.1	(2.4)	23.3	(1.1)
4-7 Drinks	12.0	(1.4)	12.8	(1.8)	6.7	(1.8)	12.4	(1.6)	12.0	(0.8)
8-11 Drinks	2.5	(0.5)	4.4	(1.6)	2.4	(0.2)	1.4	(0.4)	2.7	(0.5)
12 or more	1.1	(0.3)	0.8	(0.2)	0.2	(0.2)	0.2	(0.1)	0.7	(0.1)
W1-W4[a]										
None	54.0	(8.6)	47.7	(15.3)	+	(+)	*	(*)	53.0	(7.6)
1 Drink	7.0	(1.4)	19.0	(12.5)	+	(+)	*	(*)	10.0	(2.9)
2-3 Drinks	31.1	(7.1)	20.2	(11.1)	+	(+)	*	(*)	28.8	(6.7)
4-7 Drinks	6.1	(2.4)	12.1	(10.2)	+	(+)	*	(*)	6.5	(2.2)
8-11 Drinks	1.6	(1.4)	1.0	(1.0)	+	(+)	*	(*)	1.6	(1.2)
12 or more	0.1	(0.2)	0.0	(**)	+	(+)	*	(*)	0.1	(0.1)
O1-O3										
None	43.4	(3.6)	41.6	(5.4)	50.5	(1.1)	41.4	(1.9)	42.7	(1.7)
1 Drink	21.2	(2.8)	17.4	(2.7)	13.5	(5.4)	22.5	(1.8)	20.6	(1.5)
2-3 Drinks	28.2	(2.3)	30.8	(5.2)	27.4	(1.5)	29.2	(1.7)	29.0	(1.4)
4-7 Drinks	6.3	(1.0)	9.0	(0.9)	7.8	(4.4)	6.8	(1.8)	7.1	(0.9)
8-11 Drinks	0.6	(0.3)	1.1	(0.7)	0.8	(0.3)	0.1	(-)	0.5	(0.2)
12 or more	0.3	(0.4)	0.2	(0.3)	0.0	(**)	0.0	(**)	0.2	(0.1)
O4-O6										
None	39.1	(6.7)	29.8	(5.1)	42.4	(23.0)	28.0	(1.9)	31.4	(2.3)
1 Drink	19.1	(3.5)	22.0	(6.2)	14.8	(3.5)	27.5	(2.7)	24.0	(2.3)
2-3 Drinks	32.8	(5.4)	36.3	(2.8)	42.3	(20.4)	38.9	(3.1)	37.2	(2.4)
4-7 Drinks	8.7	(4.6)	11.9	(5.1)	0.5	(0.5)	5.1	(2.9)	7.0	(2.3)
8-11 Drinks	0.0	(**)	0.0	(**)	0.0	(**)	0.4	(0.4)	0.2	(0.2)
12 or more	0.3	(0.3)	0.0	(**)	0.0	(**)	0.1	(0.1)	0.1	(0.1)
Total										
None	47.3	(1.8)	45.0	(2.2)	49.7	(0.6)	46.5	(1.2)	46.7	(0.9)
1 Drink	9.1	(0.5)	8.2	(0.5)	9.6	(1.3)	11.9	(1.4)	9.7	(0.5)
2-3 Drinks	22.1	(1.2)	20.7	(1.3)	18.6	(1.8)	25.1	(1.3)	22.3	(0.7)
4-7 Drinks	14.5	(0.5)	16.9	(1.0)	15.0	(1.0)	13.5	(1.4)	14.9	(0.5)
8-11 Drinks	4.3	(0.5)	6.2	(0.2)	4.6	(0.2)	2.1	(0.3)	4.2	(0.2)
12 or more	2.6	(0.3)	3.0	(0.3)	2.5	(0.1)	0.9	(0.1)	2.2	(0.1)

Note: Tabled values are percentages and represent prevalence estimates with standard errors in parentheses.

[a]Estimates of use for Navy warrant officers are accompanied by rather large standard errors indicating the data have low reliability and should be interpreted with caution.

-Estimate rounds to zero.

*Not applicable.

**Informative standard error not available.

+Fewer than 20 respondents.

Table 9. Frequency of Consuming Eight or More Cans, Bottles or Glasses of Beer, Wine or Hard Liquor in a Single Day During the Past 12 Months for E1-E5's

Beverage/Frequency	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
Beer										
Never	34.9	(2.1)	26.5	(0.9)	30.9	(0.9)	46.7	(1.3)	35.1	(0.9)
Less than monthly	21.5	(0.7)	21.7	(0.4)	23.9	(0.8)	22.1	(1.0)	22.0	(0.4)
1-3 days a month	15.3	(0.8)	16.3	(0.6)	16.6	(0.3)	15.8	(1.1)	15.9	(0.4)
1-2 days a week	11.6	(0.5)	15.7	(0.6)	13.7	(0.4)	8.2	(0.5)	12.1	(0.3)
3-4 days a week	8.7	(0.8)	12.6	(0.7)	10.2	(1.4)	5.0	(0.3)	9.1	(0.4)
5-7 days a week	7.9	(0.7)	7.0	(0.6)	4.8	(0.2)	2.1	(0.2)	5.9	(0.3)
Wine										
Never	64.3	(0.8)	62.7	(0.7)	67.9	(3.6)	72.2	(1.2)	66.2	(0.6)
Less than monthly	20.8	(1.0)	24.6	(0.6)	23.0	(4.1)	19.8	(0.4)	21.9	(0.6)
1-3 days a month	9.2	(0.5)	9.1	(1.0)	6.6	(0.3)	5.8	(0.7)	8.0	(0.4)
1-2 days a week	2.9	(0.3)	1.9	(0.3)	1.6	(0.4)	1.7	(0.3)	2.2	(0.2)
3-4 days a week	1.9	(0.4)	1.3	(0.2)	0.5	(0.1)	0.4	(0.1)	1.2	(0.2)
5-7 days a week	1.0	(0.2)	0.5	(0.1)	0.3	(0.2)	0.1	(0.1)	0.6	(0.1)
Hard Liquor										
Never	49.7	(1.3)	40.3	(1.4)	47.8	(1.5)	59.7	(1.3)	49.3	(0.7)
Less than monthly	22.1	(0.9)	24.7	(0.7)	29.5	(2.6)	22.8	(0.6)	23.8	(0.5)
1-3 days a month	15.7	(1.0)	19.4	(0.8)	13.6	(0.3)	10.9	(0.8)	15.4	(0.5)
1-2 days a week	7.0	(0.6)	8.6	(0.5)	5.8	(0.2)	4.3	(0.4)	6.7	(0.3)
3-4 days a week	3.4	(0.5)	4.6	(0.6)	1.8	(0.7)	1.8	(0.3)	3.2	(0.3)
5-7 days a week	2.1	(0.2)	2.4	(0.3)	1.5	(0.7)	0.5	(0.1)	1.7	(0.1)

Note: Tabled values are percentages and represent prevalence estimates with standard errors in parentheses.

Demographic Characteristics of Drinking Levels

- There are notable differences in the distribution of drinking levels by demographic characteristics (Table 11).
- Heavy patterns of drinking (Table 11) for Total DoD occurred more often among males, whites and Hispanics, non-high school graduates, personnel aged 24 and below, personnel unmarried or married with spouse not present, personnel of pay grade E1-E5, and those who had spent 1-3 years on active duty or 7 months to 2 years at their present duty station.
- Overall analyses of alcohol prevalence have shown that most military personnel are low to moderate drinkers, but substantial proportions are frequent, heavy drinkers.

Table 16. Average Daily Consumption of Ethanol During the Past 12 Months

Pay Grade/Average Daily Ounces Ethanol	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
E1-E5										
None	10.9	(0.7)	9.1	(1.4)	13.6	(2.4)	12.9	(0.9)	11.1	(0.6)
>0.0 - 0.4	32.0	(1.5)	27.8	(0.7)	28.2	(2.6)	37.9	(1.0)	31.9	(0.7)
0.5 - 1.9	28.1	(1.0)	29.5	(0.8)	30.4	(1.1)	30.5	(0.7)	29.3	(0.5)
2.0 - 3.4	11.5	(0.4)	14.4	(0.9)	13.5	(1.5)	9.7	(0.5)	12.1	(0.3)
3.5 - 4.9	6.9	(0.6)	8.5	(0.6)	7.2	(0.6)	4.7	(0.7)	6.8	(0.3)
5.0 or more	10.6	(1.3)	10.8	(1.2)	7.1	(1.3)	4.2	(0.3)	8.7	(0.5)
E6-E9										
None	13.9	(1.6)	16.3	(1.4)	14.7	(4.2)	14.3	(1.6)	14.7	(0.9)
>0.0 - 0.4	41.0	(1.8)	44.1	(2.0)	41.7	(6.8)	46.2	(0.7)	43.4	(1.0)
0.5 - 1.9	29.4	(1.7)	26.7	(1.5)	32.6	(9.5)	28.1	(1.6)	28.5	(1.1)
2.0 - 3.4	8.9	(0.8)	8.0	(1.6)	5.7	(0.3)	6.7	(0.8)	7.8	(0.6)
3.5 - 4.9	4.0	(0.9)	2.5	(0.4)	3.7	(2.7)	2.7	(0.5)	3.2	(0.4)
5.0 or more	2.8	(0.4)	2.5	(0.6)	1.6	(1.1)	2.1	(0.7)	2.4	(0.3)
W1-W4										
None	17.9	(5.3)	20.1	(17.4)	+	(+)	a	(a)	17.2	(4.7)
>0.0 - 0.4	50.8	(7.9)	24.2	(11.3)	+	(+)	a	(a)	48.1	(7.8)
0.5 - 1.9	29.1	(6.2)	53.8	(19.4)	+	(+)	a	(a)	32.5	(6.5)
2.0 - 3.4	0.6	(0.4)	1.0	(1.0)	+	(+)	a	(a)	0.7	(0.4)
3.5 - 4.9	0.3	(0.3)	0.0	(aa)	+	(+)	a	(a)	0.3	(0.2)
5.0 or more	1.2	(0.9)	1.0	(1.0)	+	(+)	a	(a)	1.3	(0.8)
O1-O3										
None	10.0	(1.2)	10.1	(2.3)	13.1	(6.2)	8.6	(1.4)	9.7	(1.0)
>0.0 - 0.4	48.4	(2.3)	48.2	(5.7)	55.3	(6.9)	59.3	(2.0)	53.5	(1.9)
0.5 - 1.9	33.8	(2.0)	38.1	(6.9)	25.3	(2.7)	27.2	(1.6)	31.2	(1.9)
2.0 - 3.4	5.1	(0.7)	0.9	(0.4)	6.1	(3.3)	4.1	(1.1)	4.0	(0.6)
3.5 - 4.9	1.3	(0.6)	0.6	(0.4)	0.0	(aa)	0.4	(0.3)	0.7	(0.3)
5.0 or more	1.3	(0.7)	2.2	(0.9)	0.2	(0.3)	0.3	(0.2)	1.0	(0.3)
O4-O6										
None	8.1	(2.9)	4.5	(2.4)	0.5	(0.5)	10.4	(1.8)	8.3	(1.1)
>0.0 - 0.4	48.3	(2.8)	43.7	(6.6)	37.1	(15.5)	43.5	(3.8)	44.3	(2.5)
0.5 - 1.9	30.6	(3.6)	46.5	(7.2)	52.6	(19.2)	37.1	(2.5)	38.1	(2.1)
2.0 - 3.4	6.2	(2.1)	5.0	(2.3)	7.2	(4.5)	6.1	(2.7)	6.0	(1.6)
3.5 - 4.9	4.6	(2.6)	0.2	(0.1)	2.0	(1.9)	1.3	(0.5)	1.9	(0.6)
5.0 or more	2.2	(1.3)	0.1	(0.1)	0.5	(0.5)	1.7	(1.0)	1.4	(0.6)
Total										
None	11.4	(0.5)	10.3	(1.4)	13.4	(2.1)	12.5	(0.6)	11.6	(0.5)
>0.0 - 0.4	35.6	(1.1)	32.2	(1.1)	31.9	(1.6)	42.5	(1.5)	36.3	(0.7)
0.5 - 1.9	28.9	(0.6)	30.0	(0.8)	30.9	(0.2)	30.2	(0.5)	29.7	(0.3)
2.0 - 3.4	10.2	(0.5)	12.2	(0.6)	11.8	(1.2)	8.2	(0.7)	10.3	(0.3)
3.5 - 4.9	5.8	(0.3)	6.8	(0.7)	6.2	(0.6)	3.5	(0.4)	5.5	(0.3)
5.0 or more	8.2	(0.8)	8.5	(1.1)	5.8	(1.4)	3.2	(0.4)	6.7	(0.4)

Note: Tabled values are percentages and represent prevalence estimates with standard errors in parentheses. Construction of the ethanol index is based on estimates of typical drinking (quantity, frequency, and volume of alcohol) during the past 30 days and atypical drinking (frequency of 8 or more drinks) during the past 12 months for beer, wine and hard liquor. The index ranges from 0 to 30 and represents the mean number of ounces of ethanol consumed per day from all alcoholic beverages. Details of the index appear in Appendix H of the main report.

+ Fewer than 20 respondents.

a Not applicable.

aa Informative standard error not available.

Table 11. Drinking Levels by Socio-Demographic Characteristics - Total DoD

Socio-Demographic Characteristics	Drinking Levels					Total DoD
	Abstainer	Infrequent Light	Moderate	Moderate-Heavy	Heavy	
Sex						
Male	11.4	17.9	29.4	26.6	14.7	90.6
Female	15.4	28.3	33.9	14.7	7.7	9.4
Race/Ethnicity						
White	11.0	18.4	29.4	26.3	14.9	71.2
Black	13.9	19.9	33.1	21.7	11.4	16.7
Hispanic	11.9	19.1	26.0	28.4	14.6	6.9
Other	14.7	22.4	29.7	22.7	10.6	5.2
Education						
Less than high school graduate	7.2	15.7	18.8	27.8	30.5	3.7
High school graduate or GED	11.3	18.3	26.5	26.6	17.3	48.2
Beyond High School, no 4 year degree	13.3	19.2	31.0	24.7	11.9	33.1
College graduate or higher	11.1	20.8	40.5	23.3	4.3	15.0
Age						
17-20	10.2	18.8	24.7	27.4	18.9	23.0
21-24	10.0	17.6	27.3	26.7	18.4	30.6
25-30	12.8	19.7	33.1	23.6	10.9	23.2
31 or older	14.6	19.8	35.0	23.8	6.7	23.2
Marital/Accompaniment Status						
Not married	9.1	16.8	26.1	28.2	19.7	49.1
Married, spouse not present at duty station	9.2	18.7	29.0	27.4	15.7	6.9
Married, spouse present at duty station	15.1	21.2	34.1	22.2	7.4	44.0
Pay Grade						
E1-E5	11.3	18.2	26.9	26.0	17.5	69.8
E6-E9	14.9	20.5	32.3	24.3	8.0	17.2
W1-W4	17.2	15.2	38.5	24.4	4.7	1.0
O1-O3	9.8	22.7	42.9	21.3	3.3	8.1
O4-O6	8.3	16.2	42.7	29.8	3.0	3.9
Time on Active Duty						
1 year or less	11.0	22.7	27.8	25.5	13.0	16.4
>1-2 years	9.8	16.6	25.6	27.0	21.0	15.5
>2-3 years	10.1	15.9	25.1	17.6	21.3	12.1
>3-4 years	11.8	17.9	26.6	27.1	16.5	8.1
>4-9 years	11.5	19.1	32.8	24.5	12.1	25.3
10 years or more	14.8	19.4	34.4	23.9	7.5	22.6
Time at Present Duty Station						
6 months or less	11.4	20.7	29.3	25.5	13.1	29.6
7-12 months	11.0	16.9	30.3	25.8	15.9	21.8
>1 to 2 years	11.7	18.0	29.1	25.7	15.5	26.0
>2 to 3 years	11.8	18.2	30.3	26.6	13.1	13.7
More than 3 years	15.0	21.2	31.4	22.4	10.0	8.9
Region						
Americas	12.3	20.8	29.9	24.9	12.9	75.9
North Pacific	10.5	15.4	27.8	28.7	17.6	4.7
Other Pacific	9.3	14.9	30.8	29.0	16.0	3.9
Europe	9.9	15.5	30.0	26.6	18.0	15.5
Service						
Army	11.6	18.0	29.8	25.1	15.5	33.6
Navy	10.5	21.6	25.4	26.4	16.1	29.0
Marine Corps	13.5	13.4	27.3	29.4	16.4	10.9
Air Force	12.6	19.1	34.8	23.9	9.5	26.5
Total DoD	11.8	18.9	29.8	25.5	14.0	100.0

Note: Drinking Level values are row percentages. Total DoD values are column percentages. Drinking levels are based on quantity and frequency data during the past 30 days for the respondents' primary beverage. Abstainers drink once a year or less. Those in the Infrequent-Light category drink once/month at most and 1-4 drinks/occasion. Those in the Moderate category drink (a) at least once/week and 1 drink/occasion, (b) 3-4 times/month and 2-4 drinks/occasion, or (c) once/month or less and ≥5 drinks/occasion. Those in the Moderate-Heavy category drink at least once/week and 2-4 drinks/occasion or 3-4 times/month and ≥5 drinks/occasion. Those in the Heavy category drink at least once/week and ≥5 drinks/occasion.

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3. PREVALENCE OF NONMEDICAL DRUG USE

A substantial number of military personnel report use of drugs for nonmedical purposes. The amount and type of such drug use is of concern to Congressional, defense, and Service leaders since it has important implications for performance and safety within the military. The present chapter describes the prevalence and incidence of nonmedical drug use as reported by respondents for the periods of 30 days and 12 months prior to taking the survey.

Respondents to the present survey were asked to indicate their level of nonmedical use of each of the following drugs.

- Marijuana or Hashish
- PCP
- LSD and Other Hallucinogens
- Cocaine
- Amphetamines and Other Stimulants
- Tranquilizers
- Barbiturates and Other Sedatives
- Heroin
- Opiates Other than Heroin
- Other Drugs (e.g., any not included above such as over-the-counter drugs and inhalants).

Basic Patterns of Drug Use

- Overall, 42 percent of DoD personnel have used one or more drugs for nonmedical purposes, including 27 percent who have used within the past 12 months and 19 percent within the past 30 days (Table 12).
- Marijuana is the single drug most frequently used for nonmedical purposes. Of all military personnel, 40 percent have used during their lifetimes, 24 percent have used within the past 12 months, and 17 percent have used within the past 30 days (Table 12).
- For any drug besides marijuana, use is reported by 22 percent during their lifetimes, by 14 percent within the past 12 months, and by 9 percent within the past 30 days (Table 12).
- Among the Services (Table 12), the Air Force consistently shows lowest levels of any drug use during lifetime (32 percent), past 12 months (16 percent) or past 30 days (12 percent).

Table 12. Nonmedical Drug Use During the Past 30 Days, the Past 12 Months, and Ever During Lifetime

Drug/Period of Use	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
Marijuana										
Past 30 Days	23.9	(1.7)	13.4	(2.0)	17.1	(2.0)	9.6	(1.1)	16.5	(0.9)
Past 12 Months	30.5	(1.7)	25.6	(1.6)	26.4	(2.4)	14.3	(1.5)	24.3	(0.9)
Ever Used	43.7	(0.8)	44.1	(1.9)	44.3	(3.2)	30.6	(2.0)	40.2	(0.9)
PCP										
Past 30 Days	0.9	(0.2)	0.8	(0.3)	0.7	(0.2)	0.2	(-)	0.6	(0.1)
Past 12 Months	1.9	(0.3)	1.5	(0.4)	1.4	(0.1)	0.3	(0.1)	1.3	(0.1)
Ever Used	6.1	(0.5)	7.1	(0.9)	8.3	(0.4)	3.1	(0.4)	5.7	(0.3)
LSD/Hallucinogens										
Past 30 Days	2.5	(0.4)	2.5	(0.5)	4.3	(0.6)	0.6	(0.2)	2.1	(0.2)
Past 12 Months	5.6	(0.6)	6.5	(0.7)	7.1	(0.9)	1.5	(0.2)	4.8	(0.3)
Ever Used	11.1	(0.6)	13.4	(1.3)	15.1	(1.4)	5.6	(0.5)	10.5	(0.4)
Cocaine										
Past 30 Days	3.7	(0.5)	3.3	(0.8)	3.9	(0.8)	1.3	(0.4)	2.9	(0.3)
Past 12 Months	7.3	(0.8)	9.7	(1.3)	7.7	(0.3)	3.0	(0.5)	6.8	(0.5)
Ever Used	14.0	(0.6)	17.5	(1.7)	17.3	(0.6)	8.7	(0.7)	13.7	(0.5)
Amphetamines/Stimulants										
Past 30 Days	5.5	(0.7)	5.3	(1.0)	6.5	(0.2)	1.8	(0.2)	4.5	(0.4)
Past 12 Months	8.4	(0.7)	10.2	(1.4)	9.3	(0.4)	3.2	(0.4)	7.6	(0.5)
Ever Used	14.2	(0.7)	18.2	(1.7)	19.4	(1.5)	9.1	(0.7)	14.3	(0.6)
Tranquilizers										
Past 30 Days	1.6	(0.3)	1.2	(0.2)	1.4	(0.2)	0.6	(0.2)	1.2	(0.1)
Past 12 Months	3.0	(0.4)	3.4	(0.4)	2.9	(0.7)	0.9	(0.2)	2.5	(0.2)
Ever Used	7.5	(0.4)	9.3	(0.9)	8.7	(0.3)	4.5	(0.6)	7.2	(0.3)
Barbiturates/Sedatives										
Past 30 Days	1.6	(0.2)	1.1	(0.1)	1.4	(0.1)	0.7	(0.2)	1.2	(0.1)
Past 12 Months	3.2	(0.4)	3.5	(0.3)	2.8	(0.4)	1.1	(0.3)	2.7	(0.2)
Ever Used	7.8	(0.4)	10.0	(0.9)	10.1	(0.7)	4.8	(0.6)	7.8	(0.3)
Heroin										
Past 30 Days	0.8	(0.1)	0.5	(0.1)	0.9	(0.2)	0.1	(-)	0.5	(0.1)
Past 12 Months	1.3	(0.2)	0.9	(0.2)	1.2	(0.3)	0.1	(-)	0.8	(0.1)
Ever Used	3.5	(0.3)	2.7	(0.3)	3.1	(0.9)	1.0	(0.2)	2.6	(0.2)
Other Opiates										
Past 30 Days	1.1	(0.2)	0.6	(0.1)	1.0	(0.1)	0.2	(0.1)	0.7	(0.1)
Past 12 Months	1.8	(0.3)	1.7	(0.2)	1.7	(0.2)	0.5	(0.1)	1.4	(0.1)
Ever Used	5.2	(0.4)	6.1	(0.7)	6.2	(0.6)	2.6	(0.4)	4.8	(0.2)
Other Drugs										
Past 30 Days	3.9	(0.3)	2.8	(0.3)	4.4	(0.9)	2.4	(0.5)	3.2	(0.2)
Past 12 Months	5.1	(0.4)	5.3	(0.2)	6.0	(1.0)	3.0	(0.6)	4.6	(0.3)
Ever Used	9.0	(0.5)	10.3	(0.8)	12.0	(2.0)	6.0	(0.6)	8.8	(0.4)
Any Drug										
Past 30 Days	26.2	(1.8)	16.2	(2.2)	20.6	(2.0)	11.9	(1.5)	19.0	(1.0)
Past 12 Months	32.4	(1.8)	28.1	(1.7)	29.9	(3.2)	16.4	(1.8)	26.6	(1.0)
Ever Used	45.1	(0.8)	45.6	(1.9)	46.1	(3.8)	32.4	(2.3)	41.8	(0.9)
Any Drug Except Marijuana										
Past 30 Days	10.6	(1.0)	9.6	(1.6)	12.0	(1.3)	5.1	(0.8)	8.9	(0.6)
Past 12 Months	15.5	(1.2)	17.0	(1.7)	17.2	(2.0)	7.3	(1.0)	13.8	(0.7)
Ever Used	22.4	(0.8)	26.0	(1.9)	27.7	(3.3)	15.5	(1.3)	21.9	(0.7)

Note: Tabled values are percentages and represent prevalance estimates with standard errors in parentheses.

- Estimate rounds to zero.

- The Army, Navy and Marine Corps personnel (Table 12) show similar lifetime use of any drug (45-46 percent).

- The Army shows highest use of any drug during the past 12 months (32 percent) with the Marine Corps (30 percent) and Navy (28 percent) only slightly lower (Table 12).

- The Army (Table 12) shows highest use of any drug during the past 30 days (26 percent) followed by the Marine Corps (21 percent) and Navy (16 percent).

- Military personnel in pay grades E1-E5 are at least five times more likely to use drugs than personnel in other pay grades. During the past 12 months, 36 percent used one or more drugs compared to 7 percent or less for other pay grades; during the past 30 days, 26 percent used one or more drugs compared to 5 percent or less for other pay grades (Table 13).

- Patterns of use among E1-E5's (Table 14) are similar to those observed for Total DoD (Table 12) although levels of use are higher.

- Different use patterns exist among the Services for E1-E5s for the various time periods (Table 14). For "any drug," lifetime use is similar in the Army, Navy, and Marine Corps (54-55 percent) and lower in the Air Force (45 percent). However, 12-month and 30-day use are highest in the Army (42 and 34 percent, respectively), about the same in the Navy and Marine Corps, and lowest in the Air Force.

- Among E1-E5's the use pattern for marijuana across time periods is the same as that observed for any drug (Table 14). Levels of use are particularly high in the Army. Notably, 40 percent indicate use during the past 12 months and 32 percent during the past 30 days.

Use of Any Drug: Region and Pay Grade Comparisons

- Regional comparisons show overall drug use for the past 30 days is greatest in Europe (27 percent), followed by Other Pacific (20 percent), Americas (18 percent) and North Pacific (16 percent).

- Among the Services, greatest use of any drug during the past 30 days occurs in Europe for the Army (34 percent) and in the Other Pacific for the Navy (18 percent), the Marines (26 percent), and the Air Force (15 percent).

- Among E1-E5's, use of any drug during the past 30 days (Table 15) is greatest in Europe for the Army (42 percent), and in the Other Pacific for the Navy (25 percent), Marine Corps (31 percent), and Air Force (23 percent).

- Data for 12 months generally follow the pattern of the data for 30 days. Most frequent use of any drug occurs among E1-E5's in Europe for the Army (47 percent), in the Americas for the Navy (37 percent), and in the Other Pacific for the Marine Corps (41 percent) and Air Force (29 percent).

Table 13. Nonmedical Drug Use During the Past 30 Days and the Past 12 Months by Pay Grade

Drug/Period of Use	Pay Grade										Total DoD	
	E1-E5		E6-E9		W1-W4		O1-O3		O4-O6			
Marijuana												
Past 30 Days	22.5	(1.2)	3.6	(0.3)	3.1	(1.3)	1.6	(0.5)	0.4	(0.3)	16.5	(0.9)
Past 12 Months	32.9	(0.9)	5.5	(0.6)	4.8	(1.6)	4.3	(0.8)	0.9	(0.8)	24.3	(0.9)
PCP												
Past 30 Days	0.9	(0.1)	0.2	(0.1)	0.0	(**)	0.2	(0.1)	0.1	(0.1)	0.6	(0.1)
Past 12 Months	1.8	(0.2)	0.2	(0.1)	0.0	(**)	0.2	(0.1)	0.2	(0.1)	1.3	(0.1)
LSD/Hallucinogens												
Past 30 Days	3.0	(0.3)	0.2	(0.1)	0.0	(**)	0.2	(0.2)	0.1	(0.1)	2.1	(0.2)
Past 12 Months	6.7	(0.4)	0.2	(0.2)	0.0	(**)	0.7	(0.3)	0.1	(0.1)	4.8	(0.3)
Cocaine												
Past 30 Days	4.0	(0.4)	0.4	(0.1)	0.0	(**)	0.6	(0.2)	0.1	(0.1)	2.9	(0.3)
Past 12 Months	9.4	(0.6)	0.6	(0.1)	0.1	(0.1)	1.4	(0.4)	0.4	(0.3)	6.8	(0.5)
Amphetamines/Stimulants												
Past 30 Days	6.2	(0.5)	0.6	(0.1)	0.7	(0.7)	0.8	(0.3)	0.1	(0.1)	4.5	(0.4)
Past 12 Months	10.4	(0.6)	1.1	(0.2)	0.7	(0.7)	1.3	(0.5)	0.2	(0.1)	7.6	(0.5)
Tranquilizers												
Past 30 Days	1.6	(0.2)	0.2	(0.1)	0.0	(**)	0.3	(0.2)	0.2	(0.1)	1.2	(0.1)
Past 12 Months	3.4	(0.2)	0.4	(0.1)	0.0	(**)	0.7	(0.3)	0.2	(0.1)	2.5	(0.2)
Barbiturates/Sedatives												
Past 30 Days	1.6	(0.1)	0.2	(0.1)	0.0	(**)	0.2	(0.1)	0.1	(0.1)	1.2	(0.1)
Past 12 Months	3.7	(0.2)	0.4	(0.2)	0.0	(**)	0.4	(0.2)	0.1	(0.1)	2.7	(0.2)
Heroin												
Past 30 Days	0.7	(0.1)	0.1	(0.1)	0.0	(**)	0.2	(0.1)	0.1	(0.1)	0.5	(0.1)
Past 12 Months	1.1	(0.1)	0.1	(0.1)	0.0	(**)	0.2	(0.1)	0.1	(0.1)	0.8	(0.1)
Other Opiates												
Past 30 Days	1.0	(0.1)	0.0	(**)	0.0	(**)	0.2	(0.1)	0.1	(0.1)	0.7	(0.1)
Past 12 Months	1.9	(0.2)	0.1	(0.1)	0.0	(**)	0.4	(0.2)	0.1	(0.1)	1.4	(0.1)
Other Drugs												
Past 30 Days	4.2	(0.3)	1.1	(0.2)	0.3	(0.3)	1.3	(0.4)	0.5	(0.3)	3.2	(0.2)
Past 12 Months	6.0	(0.3)	1.4	(0.2)	0.4	(0.4)	1.8	(0.4)	0.5	(0.3)	4.6	(0.3)
Any Drug												
Past 30 Days	25.6	(1.3)	4.8	(0.4)	3.5	(1.3)	2.9	(0.5)	0.8	(0.4)	19.0	(1.0)
Past 12 Months	35.5	(1.0)	7.2	(0.5)	5.1	(1.5)	5.6	(0.8)	1.6	(0.5)	26.6	(1.0)
Any Drug Except Marijuana												
Past 30 Days	12.0	(0.8)	2.1	(0.3)	1.0	(0.8)	2.0	(0.5)	0.5	(0.3)	8.9	(0.6)
Past 12 Months	18.5	(0.8)	3.1	(0.3)	1.2	(0.8)	3.4	(0.7)	0.8	(0.4)	13.8	(0.7)

Note: Tabled values are percentages and represent estimates with standard errors in parentheses.

** Informative standard error not available.

Table 14. Nonmedical Drug Use During the Past 30 Days, the Past 12 Months, and Ever During Lifetime for E1-E5's

Drug/Period of Use	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
Marijuana										
Past 30 Days	31.7	(2.1)	17.5	(2.8)	21.3	(1.2)	15.0	(1.1)	22.5	(1.2)
Past 12 Months	39.7	(2.0)	33.4	(1.5)	33.0	(1.3)	22.0	(1.2)	32.9	(0.9)
Ever Used	52.3	(0.8)	53.5	(1.6)	52.8	(0.8)	42.6	(1.3)	50.3	(0.6)
PCP										
Past 30 Days	1.2	(0.2)	1.0	(0.4)	0.9	(0.3)	0.3	(0.1)	0.8	(0.1)
Past 12 Months	2.5	(0.4)	2.0	(0.5)	1.7	(0.2)	0.4	(0.1)	1.8	(0.2)
Ever Used	8.3	(0.6)	9.1	(1.4)	10.0	(0.2)	4.7	(0.4)	7.8	(0.4)
LSD/Hallucinogens										
Past 30 Days	3.4	(0.5)	3.2	(0.6)	5.4	(0.6)	1.0	(0.3)	3.0	(0.3)
Past 12 Months	7.7	(0.8)	8.6	(0.9)	8.9	(0.8)	2.3	(0.3)	6.7	(0.4)
Ever Used	14.1	(0.8)	16.8	(1.9)	18.7	(1.0)	8.3	(0.4)	13.9	(0.6)
Cocaine										
Past 30 Days	5.0	(0.6)	4.3	(1.1)	4.8	(0.7)	2.0	(0.6)	4.0	(0.4)
Past 12 Months	9.9	(1.0)	12.8	(1.6)	9.6	(0.6)	4.7	(0.7)	9.4	(0.6)
Ever Used	17.8	(0.8)	21.9	(2.5)	21.6	(1.6)	13.2	(0.5)	18.2	(0.8)
Amphetamines/Stimulants										
Past 30 Days	7.3	(0.9)	7.0	(1.3)	8.2	(0.6)	2.8	(0.3)	6.2	(0.5)
Past 12 Months	11.1	(0.9)	13.5	(1.6)	11.8	(0.3)	5.0	(0.5)	10.4	(0.6)
Ever Used	17.6	(0.9)	22.5	(2.4)	24.0	(1.0)	13.4	(0.5)	18.6	(0.7)
Tranquilizers										
Past 30 Days	2.1	(0.3)	1.6	(0.3)	1.6	(0.2)	0.8	(0.2)	1.6	(0.2)
Past 12 Months	3.9	(0.6)	4.5	(0.4)	3.5	(0.8)	1.4	(0.2)	3.4	(0.2)
Ever Used	9.5	(0.6)	11.3	(1.3)	10.5	(0.7)	6.5	(0.6)	9.4	(0.4)
Barbiturates/Sedatives										
Past 30 Days	2.1	(0.3)	1.5	(0.1)	1.7	(0.3)	1.0	(0.3)	1.6	(0.1)
Past 12 Months	4.2	(0.6)	4.7	(0.2)	3.5	(0.7)	1.7	(0.3)	3.7	(0.2)
Ever Used	9.9	(0.6)	12.5	(1.4)	12.3	(0.6)	7.0	(0.6)	10.1	(0.4)
Heroin										
Past 30 Days	1.1	(0.2)	0.7	(0.1)	1.1	(0.2)	0.1	(-)	0.7	(0.1)
Past 12 Months	1.7	(0.2)	1.1	(0.2)	1.5	(0.3)	0.1	(-)	1.1	(0.1)
Ever Used	4.6	(0.4)	3.4	(0.4)	3.9	(0.9)	1.4	(0.1)	3.4	(0.2)
Other Opiates										
Past 30 Days	1.5	(0.3)	0.8	(0.2)	1.2	(0.1)	0.3	(0.1)	1.0	(0.1)
Past 12 Months	2.4	(0.4)	2.3	(0.2)	2.1	(0.4)	0.7	(0.2)	1.9	(0.2)
Ever Used	6.8	(0.5)	7.6	(1.2)	7.5	(0.4)	3.9	(0.4)	6.4	(0.4)
Other Drugs										
Past 30 Days	5.0	(0.5)	3.5	(0.4)	5.3	(1.1)	3.4	(0.6)	4.2	(0.3)
Past 12 Months	6.5	(0.6)	6.6	(0.4)	7.1	(1.1)	4.2	(0.8)	6.0	(0.3)
Ever Used	11.2	(0.7)	12.6	(1.4)	14.2	(2.0)	8.3	(0.6)	11.2	(0.5)
Any Drug										
Past 30 Days	34.3	(2.2)	20.9	(3.1)	25.3	(1.5)	18.1	(1.4)	25.6	(1.3)
Past 12 Months	41.7	(2.1)	36.3	(1.7)	36.8	(2.4)	24.7	(1.6)	35.5	(1.0)
Ever Used	53.7	(0.7)	54.9	(1.7)	54.6	(1.7)	44.5	(1.5)	51.9	(0.6)
Any Drug Except Marijuana										
Past 30 Days	13.9	(1.2)	12.5	(2.0)	14.6	(1.2)	7.6	(1.0)	12.0	(0.8)
Past 12 Months	20.3	(1.4)	22.1	(1.9)	21.0	(1.7)	10.9	(1.2)	18.5	(0.8)
Ever Used	27.3	(1.1)	32.0	(2.6)	33.5	(2.5)	21.9	(0.9)	27.9	(0.9)

Note: Tabled values are percentages and represent prevalence estimates with standard errors in parentheses.

- Estimate rounds to zero.

Table 15. Any Drug Use Among Regions During the Past 30 Days for E1-E5's

Region	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
Americas	30.4	(3.4)	20.9	(3.4)	25.6	(1.9)	19.0	(1.8)	23.8	(1.6)
North Pacific	29.9	(0.4)	16.7	(1.1)	20.9	(2.0)	12.8	(0.8)	21.0	(0.6)
Other Pacific	40.0	(10.6)	24.7	(2.9)	31.0	(2.0)	22.8	(2.6)	28.4	(2.9)
Europe	41.8	(1.5)	14.5	(0.2)	25.1	(1.3)	14.6	(1.9)	34.6	(1.2)
Total Worldwide	34.3	(2.2)	20.9	(3.1)	25.3	(1.5)	18.1	(1.4)	25.6	(1.3)

Note: Tabled values are percentages and represent prevalence estimates with standard errors in parentheses.

Use of Marijuana/Hashish: Region and Pay Grade Comparisons

- Use of marijuana/hashish during the past 30 days and past 12 months follows the same pattern noted for any drug use. During these time periods, respectively, use is highest among E1-E5 Army personnel in Europe (39 and 45 percent); among Navy personnel in the Other Pacific (20 percent--30 day use) and Americas (34 percent--12 month use); and among Marine Corps personnel (29 and 39 percent) and Air Force personnel (19 and 26 percent) in the Other Pacific.

- Among all E1-E5's 10 percent used marijuana/hashish 1-3 days during the past 30 days, 4 percent 4-10 days, 3 percent 11-19 days, and 5 percent 20-30 days (Table 16).

- E1-E5's using marijuana 11 or more of the past 30 days occurs most often for the Army (17 percent) both in Europe and in the Other Pacific. For the Navy (9 percent), the Marine Corps (12 percent) and the Air Force (6 percent), it occurs most often in the Other Pacific (Table 16).

Use of Any Drug Except Marijuana: Region and Pay Grade Comparisons

- Use of any drug except marijuana/hashish follows a pattern similar to that of marijuana use. During the past 30 days and past 12 months, respectively, for E1-E5's the highest frequency of use occurred for the Army in Europe (16 and 22 percent) and the Other Pacific (15 and 22 percent); for the Navy in the Americas (13 and 23 percent); for the Marine Corps in the Americas (16 percent--30 day use) and North Pacific (22 percent--12 month use); and for the Air Force in the Other Pacific (9 and 13 percent).

Table 16. Frequency of Marijuana/Hashish Use During the Past 30 Days for E1-E5's

Region/Days of Use	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
Americas										
None	72.0	(3.3)	82.5	(3.1)	78.5	(1.4)	84.1	(1.3)	79.3	(1.5)
1-3	11.6	(1.4)	8.4	(1.3)	8.6	(0.6)	8.1	(1.4)	9.3	(0.7)
4-10	5.8	(0.9)	3.7	(0.8)	3.9	(0.7)	2.9	(0.6)	4.1	(0.4)
11-19	3.7	(0.7)	1.6	(0.5)	3.6	(1.4)	2.2	(0.5)	2.6	(0.4)
20-30	6.8	(1.5)	3.9	(0.8)	5.4	(1.6)	2.7	(0.6)	4.6	(0.6)
North Pacific										
None	73.7	(0.3)	85.3	(0.6)	84.0	(3.2)	89.1	(0.3)	82.3	(0.8)
1-3	12.0	(1.1)	7.4	(1.1)	8.2	(1.1)	6.4	(0.7)	8.8	(0.5)
4-10	6.3	(1.2)	4.4	(0.4)	3.7	(1.0)	2.2	(0.1)	4.2	(0.5)
11-19	4.5	(0.6)	1.2	(-)	1.6	(0.5)	1.1	(0.1)	2.3	(0.2)
20-30	3.5	(1.1)	1.8	(-)	2.4	(0.7)	1.2	(0.3)	2.3	(0.4)
Other Pacific										
None	63.4	(9.7)	79.6	(2.8)	71.2	(1.9)	80.7	(1.7)	75.2	(2.7)
1-3	14.1	(1.6)	8.7	(0.9)	13.8	(1.4)	9.4	(0.1)	10.8	(0.7)
4-10	5.3	(1.4)	3.2	(0.5)	3.4	(1.3)	3.5	(0.3)	3.7	(0.5)
11-19	4.0	(2.0)	2.0	(0.4)	4.2	(0.6)	1.2	(0.6)	2.6	(0.5)
20-30	13.2	(4.7)	6.6	(1.4)	7.4	(1.4)	5.2	(0.7)	7.7	(1.3)
Europe										
None	60.8	(1.5)	87.4	(0.6)	74.9	(1.3)	88.9	(1.1)	68.1	(1.2)
1-3	13.8	(1.0)	7.0	(0.9)	19.6	(4.0)	4.9	(1.0)	11.6	(0.8)
4-10	8.0	(0.6)	2.4	(0.8)	0.0	(**)	2.9	(0.4)	6.6	(0.4)
11-19	6.2	(0.3)	1.3	(0.7)	0.0	(**)	1.2	(0.3)	4.9	(0.2)
20-30	11.2	(0.7)	1.9	(-)	5.4	(2.7)	2.1	(0.8)	8.8	(0.5)
Total Worldwide										
None	68.3	(2.1)	82.5	(2.8)	78.7	(1.2)	85.0	(1.1)	77.5	(1.2)
1-3	12.4	(0.9)	8.3	(1.2)	9.0	(0.5)	7.6	(1.1)	9.7	(0.5)
4-10	6.5	(0.6)	3.6	(0.7)	3.8	(0.6)	2.9	(0.4)	4.5	(0.3)
11-19	4.5	(0.5)	1.6	(0.4)	3.4	(1.1)	2.0	(0.4)	3.0	(0.3)
20-30	8.2	(1.0)	3.9	(0.7)	5.1	(1.3)	2.6	(0.5)	5.3	(0.5)

Note: Tabled values are percentages and represent prevalence estimates with standard errors in parentheses.

- Estimate rounds to zero.

** Informative standard error not available.

Table 17. Frequency of Any Drug Use Except Marijuana/Hashish During the Past 30 Days for E1-E5's

Region/Days of Use	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
Americas										
None	87.3	(1.9)	87.3	(2.3)	84.5	(1.4)	92.1	(1.2)	88.2	(1.0)
1-3	7.4	(1.0)	8.1	(1.6)	9.4	(0.6)	5.0	(1.2)	7.2	(0.7)
4-10	2.8	(0.4)	2.6	(0.8)	3.2	(0.4)	1.7	(0.2)	2.5	(0.3)
11-19	1.0	(0.2)	1.0	(0.3)	1.2	(0.7)	0.3	(0.2)	0.9	(0.1)
20-30	1.5	(0.4)	1.1	(0.1)	1.7	(0.3)	0.9	(0.3)	1.2	(0.2)
North Pacific										
None	87.2	(1.2)	90.8	(0.5)	88.3	(1.6)	94.2	(1.1)	89.9	(0.7)
1-3	6.4	(0.5)	5.9	(0.8)	7.5	(0.8)	4.0	(1.0)	5.9	(0.4)
4-10	3.1	(0.9)	1.8	(0.3)	2.4	(1.1)	1.2	(0.7)	2.2	(0.5)
11-19	1.3	(0.3)	0.3	(-)	0.8	(0.2)	0.5	(0.2)	0.8	(0.1)
20-30	2.0	(0.5)	1.2	(-)	0.9	(0.3)	0.1	(0.1)	1.1	(0.2)
Other Pacific										
None	84.7	(3.7)	88.2	(2.1)	88.7	(1.6)	91.4	(1.4)	88.3	(1.3)
1-3	8.7	(2.3)	7.9	(1.6)	7.8	(2.0)	5.6	(1.0)	7.5	(0.9)
4-10	2.3	(0.7)	2.1	(0.4)	1.9	(1.2)	1.3	(0.4)	1.9	(0.3)
11-19	2.0	(1.0)	0.9	(0.4)	0.3	(0.3)	1.3	(0.8)	1.1	(0.4)
20-30	2.3	(0.4)	0.9	(0.2)	1.3	(0.4)	0.4	(-)	1.1	(0.1)
Europe										
None	83.8	(1.3)	93.6	(0.6)	100.0	(0.0)	93.9	(0.8)	86.5	(1.0)
1-3	9.1	(0.7)	4.9	(0.7)	0.0	(**)	4.0	(0.8)	7.7	(0.6)
4-10	3.3	(0.5)	0.9	(0.1)	0.0	(**)	0.9	(0.2)	2.6	(0.3)
11-19	1.4	(0.3)	0.6	(0.1)	0.0	(**)	0.5	(0.1)	1.1	(0.2)
20-30	2.5	(0.4)	0.0	(**)	0.0	(**)	0.7	(0.2)	2.0	(0.3)
Total Worldwide										
None	86.1	(1.2)	87.5	(2.0)	85.4	(1.2)	92.4	(1.0)	88.0	(0.8)
1-3	7.9	(0.7)	8.0	(1.5)	9.0	(0.5)	4.8	(0.9)	7.3	(0.5)
4-10	3.0	(0.3)	2.5	(0.7)	3.0	(0.4)	1.5	(0.2)	2.5	(0.2)
11-19	1.2	(0.2)	1.0	(0.2)	1.1	(0.6)	0.4	(0.1)	0.9	(0.1)
20-30	1.8	(0.3)	1.0	(0.1)	1.5	(0.2)	0.8	(0.2)	1.3	(0.1)

Note: Tabled values are percentages and represent prevalence estimates with standard errors in parentheses.

- Estimate rounds to zero.

** Informative standard error not available.

- During the past 30 days, 7 percent of E1-E5's used any drug except marijuana/hashish on 1-3 days; 2 percent on 4-10 days; 1 percent on 11-19 days; and 1 percent on 20-30 days (Table 17).

- E1-E5's using drugs on 11 or more of the past 30 days occurs most often for the Army (4 percent) in Europe and the Other Pacific. The other Services all show less than 3 percent use, with minor regional differences (Table 17).

Drugs Used Most Often Excluding Marijuana

- Amphetamines, cocaine, and LSD/hallucinogens are the most frequently used drugs other than marijuana.

- Levels of use of these drugs for E1-E5 personnel during the past 12 months are 10 percent for amphetamines, 9 percent for cocaine, 7 percent for LSD/hallucinogens, and 6 percent for other drugs; comparable figures for the past 30 days are 6 percent, 4 percent, 3 percent, and 4 percent.

Multiple Drug Use

- Single drug use is the most frequent pattern of drug use, although multiple drug use is substantial. During the past 30 days, 16 percent of E1-E5's used one drug and 9 percent used two or more (Table 18); during the past 12 months, 19 percent used one drug and 16 percent two or more.

- Multiple drug use during the past 30 days (i.e. 2 or more drugs) is somewhat more common in Europe than in other regions (11 percent versus 8 to 9 percent) and less common among Air Force personnel than other branches of the Service (Table 18). For multiple drug use during the past 12 months, there is little difference among regions (15-16 percent).

Combined Use of Drugs and Alcohol

- Individuals who use drugs may use alcohol at the same time. Overall 26 percent of E1-E5's reported using drugs and alcohol together; 25 percent combined marijuana and alcohol use, and 10 percent combined drugs other than marijuana with alcohol. The information on combined use was not placed in a time context, so it cannot be readily compared with prevalence data in Table 14.

- There is a clear relationship between the use of drugs during the past 12 months and use of larger amounts of alcohol. For E1-E5's, use of one or more drugs occurred for 8 percent of abstainers, 25 percent of infrequent-light drinkers, 30 percent of moderate drinkers, 43 percent of moderate-heavy drinkers and 60 percent of heavy drinkers.

Table 18. Number of Drugs Used During the Past 30 Days by E1-E5's

Region/Number of Drugs	Service									
	Army		Navy		Marine Corps		Air Force		Total DoD	
Americas										
1 Drug	19.8	(1.9)	11.1	(1.6)	13.5	(0.7)	13.8	(1.3)	14.7	(0.9)
2 Drugs	5.6	(1.2)	5.1	(1.2)	5.6	(0.4)	3.2	(0.5)	4.8	(0.6)
3 Drugs	2.0	(0.5)	2.1	(0.5)	3.3	(0.8)	1.2	(0.2)	2.0	(0.3)
4 or More Drugs	3.1	(0.7)	2.6	(0.4)	3.2	(-)	0.8	(0.3)	2.4	(0.3)
Total	30.4	(3.4)	20.9	(3.4)	25.6	(1.9)	19.0	(1.8)	23.8	(1.6)
North Pacific										
1 Drug	19.7	(0.4)	9.3	(1.2)	13.3	(1.5)	8.5	(0.3)	13.5	(0.4)
2 Drugs	4.9	(0.6)	4.1	(0.2)	3.9	(0.5)	2.3	(1.0)	3.8	(0.4)
3 Drugs	2.1	(0.6)	1.8	(0.3)	1.4	(0.4)	1.1	(0.2)	1.6	(0.2)
4 or More Drugs	3.2	(1.0)	1.5	(-)	2.4	(0.9)	1.0	(0.5)	2.1	(0.4)
Total	29.9	(0.4)	16.7	(1.1)	20.9	(2.0)	12.8	(0.8)	21.0	(0.6)
Other Pacific										
1 Drug	27.5	(8.1)	17.2	(1.3)	21.5	(0.6)	17.2	(2.0)	20.0	(2.0)
2 Drugs	4.8	(1.5)	4.1	(1.3)	4.3	(0.1)	3.3	(0.9)	4.1	(0.6)
3 Drugs	3.1	(0.7)	1.7	(0.5)	2.3	(0.5)	1.0	(0.7)	1.9	(0.4)
4 or More Drugs	4.6	(0.3)	1.7	(0.4)	2.9	(0.8)	1.3	(0.4)	2.4	(0.3)
Total	40.0	(10.6)	24.7	(2.9)	31.0	(2.0)	22.8	(2.6)	28.4	(2.9)
Europe										
1 Drug	27.7	(1.0)	9.8	(0.6)	25.1	(1.3)	11.2	(1.9)	23.4	(0.8)
2 Drugs	7.7	(0.8)	2.5	(0.7)	0.0	(**)	2.1	(0.2)	6.2	(0.6)
3 Drugs	2.8	(0.4)	1.3	(0.3)	0.0	(**)	0.7	(0.2)	2.2	(0.3)
4 or More Drugs	3.7	(0.6)	0.9	(0.8)	0.0	(**)	0.6	(0.1)	2.9	(0.4)
Total	41.8	(1.5)	14.5	(0.2)	25.1	(1.3)	14.6	(1.9)	34.6	(1.2)
Total Worldwide										
1 Drug	22.5	(1.2)	11.4	(1.5)	14.1	(0.5)	13.3	(1.1)	16.2	(0.7)
2 Drugs	6.2	(0.8)	5.0	(1.0)	5.2	(0.3)	3.0	(0.4)	5.0	(0.4)
3 Drugs	2.3	(0.4)	2.0	(0.5)	3.0	(0.7)	1.1	(0.2)	2.0	(0.2)
4 or More Drugs	3.3	(0.4)	2.5	(0.4)	3.0	(0.1)	0.8	(0.2)	2.4	(0.2)
Total	34.3	(2.2)	20.9	(3.1)	25.3	(1.5)	18.1	(1.4)	25.6	(1.3)

Note: Tabled values are percentages and represent prevalence estimates with standard errors in parentheses.

-Estimate rounds to zero.

** Informative standard error not available.

Demographic Characteristics of Drug Users

The likelihood of drug use (Table 19) is greatest among those with less than a high school education (48 percent), those aged 17-20 (43 percent), those not married (37 percent), those of pay grade E1-E5 (36 percent), those on active duty 4 years or less (about 37 percent), those stationed in Europe (31 percent), and those at their present duty station 2 years or less (about 27 percent).

Table 19. Any Drug Use During Past 12 Months by Socio-Demographic Characteristics

Socio-Demographic Characteristics	Service/Drug Use Past 12 Months									
	Army		Navy		Marine Corps		Air Force		Total DoD	
	Users	Total	Users	Total	Users	Total	Users	Total	Users	Total
Sex										
Male	32.2	87.7	28.5	94.2	29.5	96.0	16.2	88.9	26.6	90.5
Female	33.2	12.3	22.6	5.8	39.3	4.0	18.4	11.1	26.7	9.5
Race/Ethnicity										
White	32.3	60.4	28.6	77.4	30.2	72.3	15.8	78.2	25.9	71.0
Black	33.4	24.9	30.0	10.7	27.8	14.7	17.7	12.8	29.0	16.8
Hispanic	32.3	9.2	29.3	5.5	30.6	9.1	21.9	4.9	29.5	7.0
Other	27.1	5.5	18.2	6.4	29.8	3.9	17.9	4.1	22.3	5.2
Education										
Less than high school graduate	50.9	5.3	41.4	4.3	55.5	4.8	42.3	0.7	48.0	3.7
High school graduate or GED	39.4	50.4	31.6	56.0	30.5	58.0	24.4	33.3	33.0	47.8
Beyond high school, no 4 year degree	26.3	30.5	26.7	29.5	29.4	27.4	17.0	42.6	23.3	33.3
College graduate or higher	12.8	13.8	2.9	10.3	14.7	9.8	3.1	23.4	7.9	15.2
Age										
17-20	51.6	23.4	38.2	31.3	38.9	30.8	36.1	12.2	42.9	23.0
21-24	40.5	31.4	37.8	29.3	36.9	39.4	26.8	27.6	35.9	30.5
25-30	23.9	25.3	21.3	19.6	16.4	18.5	12.6	25.4	19.3	23.2
31 or older	7.6	19.9	4.7	19.8	2.8	11.4	4.0	34.7	5.2	23.3
Marital/Accompaniment Status										
Not married	43.9	49.6	37.4	59.0	36.8	56.8	26.4	36.3	37.4	49.0
Married, spouse not present at duty station	26.8	9.1	22.5	7.4	28.8	6.0	16.5	3.7	24.2	6.9
Married, spouse present at duty station	19.7	41.3	13.1	33.6	19.5	37.2	10.3	60.0	14.8	44.1
Pay Grade										
E1-E5	41.7	70.5	36.3	74.1	36.8	78.3	24.7	61.5	35.5	69.6
E6-E9	12.2	17.4	5.3	17.3	4.5	13.0	3.5	18.3	7.2	17.2
W1-W4	5.9	2.3	0.0	0.4	*	*	*	*	5.1	1.0
O1-O3	8.3	7.4	5.3	5.4	6.9	6.2	3.4	12.4	5.6	8.2
O4-O6	2.3	2.4	1.3	2.8	0.7	1.9	1.5	7.7	1.6	4.0
Time on Active Duty										
1 year or less	40.3	16.6	32.8	28.0	36.7	12.9	25.4	6.9	34.9	16.6
>1 to 2 years	48.2	16.8	45.4	12.2	38.8	20.2	29.5	12.7	41.9	14.7
>2 to 3 years	43.7	13.4	37.6	11.1	34.0	16.5	28.8	10.4	37.5	12.2
>3 to 4 years	36.8	7.2	37.3	7.4	40.5	13.0	24.9	8.5	34.0	8.2
>4 to 9 years	27.0	27.9	26.1	22.3	23.1	23.1	15.4	26.3	23.1	25.5
10 years or more	8.4	18.1	3.5	19.0	7.6	14.3	4.9	35.2	5.7	22.8

(continued)

Table 19 (continued)

Socio-Demographic Characteristics	Service/Drug Use Past 12 Months									
	Army		Navy		Marine Corps		Air Force		Total DoD	
	Users	Total	Users	Total	Users	Total	Users	Total	Users	Total
Region										
Americas	29.9	63.5	29.1	88.8	29.7	79.6	16.4	78.3	25.7	75.9
North Pacific	28.9	4.3	21.5	2.7	29.7	12.8	16.0	4.6	24.4	4.7
Other Pacific	31.8	2.3	23.0	6.0	34.6	6.4	19.7	3.4	25.7	4.0
Europe	38.0	29.9	14.4	2.4	20.2	1.2	15.6	13.7	31.3	15.4
Time at Present Duty Station										
6 months or less	32.8	30.0	28.2	40.7	32.6	23.8	17.7	20.2	28.2	29.6
7 to 12 months	35.8	27.4	31.3	17.7	30.0	27.7	21.4	16.5	31.1	21.8
>1 to 2 years	34.0	25.4	29.8	24.6	30.0	26.3	17.5	28.5	27.5	26.1
>2 to 3 years	26.6	12.1	21.7	12.6	27.5	13.3	16.8	16.9	22.1	13.7
More than 3 years	15.9	5.1	24.4	4.4	25.2	8.9	8.3	17.9	13.5	8.8
Total	32.3	-	28.1	-	29.9	-	16.4	-	26.5	100.0

Note: For each Service, values under the "Total" heading are column percentages showing the distribution across each characteristic within that Service. The values under the "Users" heading are row percentages showing the proportion of persons with each row's characteristic who also used drugs during the past 12 months.

+ Less than 20 respondents.

a Not applicable.

4. NEGATIVE EFFECTS OF ALCOHOL AND NONMEDICAL DRUG USE

The use of alcohol and drugs by military personnel results in varying degrees of negative consequences. These include work impairment, physical damage, the disruption of social relationships, and other consequences such as participation in detoxification, rehabilitation, or treatment programs. These negative effects may arise from dependence on alcohol and drugs or may be experienced without such dependence. In either case these negative effects are highly disruptive of the health, social life, and work performance of military personnel. Measures of negative effects are of three types: serious consequences arising from incidents associated with alcohol use and drug use; dependence on alcohol or drugs; and alcohol use problems.

Alcohol Use

Negative effects associated with alcohol use are evident among all Services and are closely associated with the level of alcohol consumption.

Serious Consequences of Alcohol Use.

- During the past 12 months, 18 percent of all military personnel experienced one or more serious consequences of alcohol use (Table 20). Prevalence rates are higher among the Marine Corps (23 percent), Navy (21 percent), and Army (19 percent) than among the Air Force (11 percent).

- There was little difference in the percentages of incidents involving social disruption (11 percent), physical damage (10 percent), and work impairment (9 percent). "Other consequences" (7 percent) occurred least often (Table 20).

- Loss of productivity associated with alcohol use during the past year was 34 percent for Total DoD (Table 21).

- Lowered performance (30 percent) is the most frequently mentioned indicator of productivity loss (Table 21).

- Among pay grades, productivity loss due to alcohol (Table 21) is highest among E1-E5's (40 percent) but is also reported by substantial segments of other pay grades (19 to 22 percent). Among Services, the loss is highest in the Navy (42 percent) and Marines (38 percent) and lowest in the Army (33 percent) and Air Force (28 percent).

- The occurrence of serious consequences is positively related to the average daily consumption of ethanol. The percentage who experience one or more consequences increases as average daily ethanol volume increases (Table 22).

Table 20. Serious Consequences of Alcohol Use During the Past 12 Months

Consequences	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
Work Impairment										
Received UCMJ punishment[b]	3.7	(0.5)	3.3	(0.6)	4.2	(1.0)	1.8	(0.4)	3.1	(0.3)
Lower performance rating[b]	2.7	(0.3)	2.8	(0.4)	4.6	(0.7)	1.3	(0.3)	2.5	(0.2)
Loss of 3 or more working days	7.2	(0.6)	8.5	(0.8)	6.9	(2.0)	3.4	(0.4)	6.4	(0.4)
Total with any work impairment	10.2	(0.8)	10.6	(0.9)	11.2	(2.0)	5.0	(0.6)	8.9	(0.4)
Physical Damage										
Illness kept from duty 1 week or longer	1.9	(0.3)	0.9	(0.1)	1.2	(0.5)	0.5	(0.1)	1.2	(0.1)
Hospitalized for 2 or more days	0.7	(0.1)	0.7	(0.2)	1.1	(0.1)	0.4	(0.1)	0.7	(0.1)
Visited physician 2 or more times	0.7	(0.2)	1.1	(0.1)	0.5	(0.3)	0.4	(0.1)	0.7	(0.1)
Hurt in accident[a]	2.9	(0.2)	3.5	(0.4)	3.4	(0.1)	1.5	(0.3)	2.7	(0.2)
Had accident causing injury to others or property damage[b]	2.7	(0.3)	3.0	(0.2)	1.7	(0.3)	1.3	(0.3)	2.3	(0.1)
Total with any physical damage	11.7	(0.9)	12.9	(1.3)	9.6	(0.9)	5.5	(0.5)	10.1	(0.5)
Social Disruption										
Spouse left[b]	1.4	(0.2)	0.7	(0.1)	0.8	(0.1)	0.5	(0.1)	0.9	(0.1)
Spouse threatened to leave[b]	3.1	(0.3)	1.9	(0.4)	2.0	(0.5)	1.8	(0.2)	2.3	(0.2)
Arrested for driving under the influence[b]	3.7	(0.4)	3.1	(0.5)	4.9	(1.0)	2.2	(0.3)	3.2	(0.2)
Arrested for nondriving drinking incident[b]	1.9	(0.5)	3.0	(0.3)	3.2	(0.5)	1.4	(0.2)	2.6	(0.2)
Incarcerated[b]	3.3	(0.4)	3.3	(0.5)	4.3	(0.2)	1.5	(0.1)	2.9	(0.2)
Fights	5.5	(0.6)	7.0	(0.6)	7.3	(0.6)	2.1	(0.2)	5.1	(0.3)
Total with any social disruption	11.6	(1.1)	12.6	(1.1)	14.3	(1.1)	6.3	(0.6)	10.6	(0.5)
Total with one or more of above consequences[a]	18.1	(1.1)	20.4	(1.5)	21.5	(1.0)	10.0	(1.0)	16.8	(0.6)
Other Consequences										
Did not get promoted[b]	2.5	(0.3)	1.3	(0.2)	2.9	(0.3)	0.7	(0.2)	1.7	(0.1)
Detoxified	1.2	(0.2)	1.4	(0.1)	0.6	(-)	0.4	(0.1)	1.0	(0.1)
Hit spouse or children[b]	3.8	(0.4)	2.7	(0.4)	2.3	(0.2)	1.8	(0.3)	2.8	(0.2)
Entered rehabilitation or treatment program[b]	3.9	(0.4)	4.0	(0.4)	6.0	(0.8)	2.4	(0.5)	3.7	(0.2)
Total with any "other consequences"	8.1	(0.7)	7.2	(0.9)	9.6	(1.1)	4.3	(0.6)	6.9	(0.4)
Total with one or more of any consequences listed above	19.3	(1.1)	21.3	(1.5)	23.2	(0.8)	10.6	(1.0)	17.7	(0.6)
Total with one or more of consequences listed included in Burt and Biegel (1980)[c]	15.2	(1.1)	15.3	(1.5)	17.6	(1.8)	8.7	(1.1)	13.6	(0.6)

Note: Tabled values are percentages and represent prevalence estimates with standard errors in parentheses.

[a]All items were included in the Rand Air Force Study (Polich and Orvis, 1979).

[b]Items included in 1980 DoD study (Burt and Biegel, 1980).

[c]All items are from the 1980 study. "I attended a special training or education program because of a problem related to my drinking" was excluded from the 1982 study. Because those who might respond positively to this "special training or education" item are highly likely to have responded positively to other items, the effect on the total scores for the 1980 and 1982 surveys is probably insignificant.

-Estimate rounds to zero.

Table 21. Loss of Productivity Because of Alcohol Use During the Past 12 Months

Productivity Item/ Pay Grade	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
Lowered Performance										
E1-E5	31.9	(1.1)	41.8	(2.7)	35.9	(2.0)	28.4	(1.8)	34.2	(0.9)
E6-E9	16.3	(1.3)	23.4	(0.7)	16.7	(3.4)	17.6	(1.4)	18.6	(0.7)
W1-W4	14.4	(3.4)	19.3	(11.0)	+	(+)	*	(*)	16.5	(3.9)
01-03	18.8	(3.6)	26.5	(4.4)	20.2	(4.0)	20.6	(2.9)	21.0	(1.9)
04-06	19.0	(2.7)	23.1	(3.3)	31.8	(8.0)	16.6	(1.7)	19.1	(1.4)
Total	27.5	(0.8)	37.2	(2.1)	32.5	(1.3)	24.5	(1.6)	29.7	(0.7)
Late for Work or Left Work Early										
E1-E5	18.8	(1.3)	20.7	(2.2)	18.5	(1.6)	16.3	(1.0)	18.7	(0.8)
E6-E9	10.1	(1.0)	8.5	(1.1)	8.5	(1.6)	8.0	(1.1)	9.0	(0.6)
W1-W4	4.1	(1.1)	1.6	(1.4)	+	(+)	*	(*)	3.8	(0.9)
01-03	9.0	(1.4)	6.3	(2.2)	11.2	(6.2)	7.7	(1.0)	8.1	(0.8)
04-06	6.6	(3.6)	4.0	(1.2)	2.5	(2.0)	2.9	(0.7)	3.9	(1.0)
Total	15.9	(1.0)	17.2	(1.4)	16.4	(0.7)	12.7	(1.0)	15.4	(0.6)
Did Not Come to Work										
E1-E5	7.3	(0.6)	6.1	(0.7)	4.3	(0.9)	3.5	(0.5)	5.7	(0.3)
E6-E9	2.8	(0.8)	1.1	(0.5)	2.5	(0.3)	0.9	(0.3)	1.7	(0.4)
W1-W4	0.4	(0.4)	0.0	(**)	+	(+)	*	(*)	0.4	(0.4)
01-03	1.0	(0.6)	0.3	(0.2)	3.0	(4.0)	1.4	(0.4)	1.2	(0.3)
04-06	2.2	(1.3)	0.7	(0.4)	0.0	(**)	0.1	(0.1)	0.6	(0.3)
Total	5.8	(0.5)	4.7	(0.7)	3.9	(1.0)	2.4	(0.4)	4.4	(0.3)
Drunk or High While Working										
E1-E5	16.0	(1.1)	18.2	(1.6)	14.4	(1.6)	8.4	(1.1)	14.6	(0.6)
E6-E9	4.9	(0.9)	4.3	(1.2)	5.3	(0.5)	3.1	(0.6)	4.2	(0.5)
W1-W4	0.9	(0.7)	1.2	(1.2)	+	(+)	*	(*)	0.9	(0.6)
01-03	1.6	(0.7)	2.7	(0.9)	0.7	(0.4)	3.0	(0.8)	2.3	(0.4)
04-06	3.0	(1.5)	3.9	(2.5)	2.0	(1.9)	0.5	(0.3)	1.8	(0.6)
Total	12.4	(0.9)	14.5	(1.3)	12.1	(1.8)	6.2	(0.9)	11.2	(0.5)
Total With Any Productivity Loss										
E1-E5	38.6	(1.1)	47.4	(2.5)	41.6	(2.4)	33.2	(1.7)	40.1	(0.9)
E6-E9	20.3	(1.7)	25.3	(0.8)	20.8	(2.3)	19.3	(1.7)	21.4	(0.8)
W1-W4	16.6	(3.6)	19.3	(11.0)	+	(+)	*	(*)	18.5	(3.9)
01-03	19.9	(3.7)	27.7	(4.3)	23.4	(8.0)	21.5	(2.8)	22.2	(1.9)
04-06	19.3	(2.7)	23.3	(3.3)	31.8	(8.0)	16.9	(1.7)	19.3	(1.4)
Total	33.1	(0.8)	41.7	(1.8)	37.6	(1.2)	28.0	(1.7)	34.4	(0.7)

Note: Tabled values are percentages and represent prevalence estimates with standard errors in parentheses.

+Less than 20 respondents.

*Not applicable.

**Informative standard error not available.

Table 22. Relationship of Serious Consequences and Alcohol Dependence to Average Daily Consumption of Ethanol

Service/Item	Average Daily Ounces of Ethanol Consumed						
	None[a] (No Drinks)	0.01-0.40 (<1 Drink)	0.41-2.16 (1-4 Drinks)	2.17-3.60 (5-7 Drinks)	3.61-6.00 (8-12 Drinks)	More than 6.0 ounces (>12 Drinks)	5.0 ounces or more (>10 Drinks)[b]
Army							
Any serious consequences	1.1	4.7	17.3	36.2	46.4	63.6	59.1
Alcohol dependent	0.8	0.4	6.3	20.9	37.8	61.5	57.6
Navy							
Any serious consequences	0.4	5.5	18.3	39.2	49.6	62.3	61.6
Alcohol dependent	0.4	0.9	6.0	24.9	38.9	58.4	54.2
Marine Corps							
Any serious consequences	1.3	7.5	19.3	46.4	55.1	68.8	62.5
Alcohol dependent	0.0	0.0	7.3	24.6	35.0	61.9	56.6
Air Force							
Any serious consequences	0.6	2.4	12.5	33.2	35.8	37.8	38.6
Alcohol Dependent	0.0	0.5	2.6	16.7	25.2	35.6	34.4
Total DoD							
Any serious consequences	0.8	4.3	16.4	37.6	46.3	60.8	57.5
Alcohol dependent	0.4	0.5	5.3	21.7	35.5	57.7	53.2

Note: Values in the table are percentages.

[a]That those drinking "none" could experience any serious consequences is possible for at least two reasons. First, someone who drank on only a few occasions during the past year could be characterized by an average daily consumption level of "none;" he thus could have legitimately experienced one or more serious consequences associated with episodic drinking. Second, the experiencing of serious consequences could be an instance of misattribution of a nonalcohol-related event to alcohol (e.g. lowered performance ratings, fights).

[b]This column is presented separately since an average daily consumption of 5.0 or more ounces of ethanol represents a commonly accepted threshold of presumptive medical harm (e.g., cirrhosis, organic brain damage).

Alcohol Dependence

- The prevalence of alcohol dependence is 9 percent overall (Table 23). Among pay grades it is highest for E1-E5 personnel (12 percent versus 1-4 percent for other pay grades). Among Services, the Army (11 percent), Navy (12 percent) and Marines (10 percent) report similar levels that exceed those among Air Force personnel (4 percent).

- Alcohol dependence is positively related to average daily consumption of alcohol. The percentage who are alcohol dependent increases as ethanol consumption increases. Nearly all dependence occurs at average ethanol levels over 2.17 ounces or 5 drinks/day (Table 22).

- Alcohol intoxication during the past 12 months occurred for 53 percent of DoD personnel. Intoxication occurred more often among E1-E5 personnel (60 percent) than within other pay grades (E6-E9, 37 percent; W1-W4, 29 percent; 01-03, 40 percent; 04-06, 31 percent). Intoxication was more common among Navy (60 percent) and Marine Corps (58 percent) personnel than among Army (51 percent) or Air Force (46 percent) personnel.

Alcohol Problems

- Alcohol use problem categories indicate that 78 percent of all personnel are not affected by alcohol use (i.e., they do not experience adverse consequences or become dependent from drinking). Nearly all officers (95-96 percent) fit this category (Table 23).

- Problems resulting from alcohol use (i.e., either adverse effects and not dependent, or dependent) occur more often among E1-E5's (28 percent) and E6-E9's (13 percent) than among officers (3-5 percent). Among Services, the Army (25 percent), Navy (27 percent) and Marine Corps (28 percent) personnel report more problems than Air Force (14 percent) personnel (Table 23).

- Personnel classified as alcohol dependent experience more negative effects than those not affected or than those affected but not dependent. They show more negative effects in work and social relationships, drink more heavily, and are more involved in the use of drugs (Table 24).

- Personnel with alcohol problems tend to be males, less educated, younger, single, of rank E1-E5, on active duty 4 years or less, stationed in the North Pacific or Europe, and at the present duty station 3 years or less (Table 25).

Drug Use

Negative effects associated with drug use are apparent among the Services and are closely associated with the level of drug consumption.

Table 23. Alcohol Use Problem Categories

Pay Grade/Problem Category	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
E1-E5										
Not Affected[a]	70.0	(1.9)	66.9	(1.6)	67.6	(0.8)	81.7	(0.9)	71.8	(0.8)
Adverse Effects, Not Dependent[b]	16.4	(0.9)	18.4	(0.9)	20.1	(1.2)	12.9	(0.6)	16.5	(0.4)
Dependent[c]	13.6	(1.1)	14.7	(1.0)	12.3	(1.7)	5.4	(0.9)	11.7	(0.5)
E6-E9										
Not Affected	83.1	(1.8)	88.0	(1.3)	87.1	(1.6)	91.8	(0.9)	87.3	(0.8)
Adverse Effects, Not Dependent	12.5	(1.5)	8.3	(0.6)	9.2	(2.6)	6.0	(0.5)	9.2	(0.6)
Dependent	4.4	(0.9)	3.7	(0.9)	3.7	(1.1)	2.2	(0.6)	3.5	(0.5)
W1-W4										
Not Affected	96.0	(1.8)	99.0	(1.0)	+	(+)	*	(*)	96.3	(1.5)
Adverse Effects, Not Dependent	3.5	(1.7)	1.0	(1.0)	+	(+)	*	(*)	3.3	(1.4)
Dependent	0.5	(0.3)	0.0	(**)	+	(+)	*	(*)	0.4	(0.3)
O1-O3										
Not Affected	95.4	(1.2)	93.4	(2.5)	91.1	(7.2)	95.5	(0.8)	94.8	(0.8)
Adverse Effects, Not Dependent	3.3	(1.1)	4.5	(1.8)	6.5	(8.2)	3.0	(0.4)	3.6	(0.7)
Dependent	1.3	(0.6)	2.1	(0.9)	2.4	(1.0)	1.5	(0.6)	1.6	(0.4)
O4-O6										
Not Affected	95.6	(1.7)	94.4	(5.3)	97.4	(2.0)	97.2	(1.6)	96.3	(1.4)
Adverse Effects, Not Dependent	1.3	(1.4)	5.1	(5.2)	2.6	(2.0)	2.5	(1.5)	2.7	(1.3)
Dependent	3.1	(1.4)	0.5	(0.4)	0.0	(**)	0.3	(0.2)	1.0	(0.4)
Total										
Not Affected	75.4	(1.4)	72.9	(1.6)	72.3	(1.7)	86.4	(1.1)	77.6	(0.7)
Adverse Effects, Not Dependent	14.1	(0.7)	15.5	(0.7)	17.4	(0.5)	9.6	(0.7)	13.5	(0.4)
Dependent	10.5	(0.8)	11.6	(1.0)	10.3	(1.8)	4.0	(0.7)	9.0	(0.5)

Note: Tabled values are column percentages for each pay grade group and represent prevalence estimates with standard errors in parentheses.

[a]Experienced no serious consequences, had average ethanol consumption in range 0-4.9 ounces/day (mean value of .7 ounces) and were not dependent.

[b]Experienced one or more serious consequences (problems) but were not dependent, or consumed 5 or more ethanol ounces but were not dependent.

[c]Experienced any of four symptoms due to drinking: blackouts, tremors (shakes), impaired control (couldn't stop drinking until drunk) or morning drinking.

*Not applicable.

**Informative standard error not available.

+Fewer than 20 respondents.

Table 24. Drinking Characteristics Within Alcohol Use Problem Categories - Total DoD

Drinking Characteristics	Alcohol Use Problem Category[a]		
	Not Affected	Adverse Effects Not Dependent	Dependent
General Drinking Characteristics			
Average Daily Consumption of Ethanol (mean ounces)	0.7	3.1	5.3
Drinking Levels: Abstainer (percent)	14.5	1.6	0.5
Infrequent/Light (percent)	21.3	11.2	9.7
Moderate (percent)	34.6	17.9	7.5
Moderate/Heavy (percent)	23.7	35.2	27.7
Heavy (percent)	5.9	34.1	54.6
"Frequent" Drinkers, past 30 days (percent who drank an alcoholic beverage 11 or more days)	18.5	49.8	64.2
"Heavy" Drinkers, past 30 days (percent who had 8 or more drinks of an alcoholic beverage on typical drinking day)	7.3	35.5	60.3
Consumed 8 or more drinks a day at least once a week, past 12 months (percent)	11.2	53.8	84.2
Heavy Drinking Days, past 12 months (number of days consumed 8 or more drinks, median)	1.5	82.5	213.5
Work-Related Characteristics			
Agreed with "there are times at work when I need a drink" (percent)	7.5	20.4	41.9
Used alcohol before or during work on at least one work day, past 30 days (percent)	11.8	30.7	47.2
Days used alcohol before or during work, past 30 days (mean)	0.4	1.8	4.3
Days lost from work because of drinking, past 12 months (mean)	0.2	1.8	5.5
Days hospitalized because of drinking, past 12 months (mean)	0.0	0.3	1.2
Drinking-Related Serious Consequences, Past 12 Months			
Reported 2 or more serious consequences (percent)	0.0	33.2	44.5
Involved in accident because of drinking (percent)	0.0	16.4	20.8
Spouse left or threatened to leave because of drinking (percent)	0.0	9.7	12.4
Hit spouse or children because of drinking (percent)	0.0	7.2	13.9
Arrested for drinking (percent)	0.0	22.6	21.2
Involved in fights while drinking (percent)	0.0	25.7	18.6
Drug-Related Characteristics			
Number of kinds of drugs used, past 30 days (mean)	0.3	1.1	2.0
"Frequent" Marijuana Users, past 30 days (percent using 11 or more days)	3.0	12.0	21.2

[a]See Table 23 for description of categories.

Table 25. Alcohol Use Problems by Socio-Demographic Characteristics

Socio-Demographic Characteristic	Service/Alcohol Use Problems									
	Army		Navy		Marine Corps		Air Force		Total DoD	
	Adverse Effects or Dependent	Total	Adverse Effects or Dependent	Total	Adverse Effects or Dependent	Total	Adverse Effects or Dependent	Total	Adverse Effects or Dependent	Total
Sex										
Male	26.3	87.9	27.8	94.3	27.8	96.1	14.4	88.9	23.6	90.6
Female	12.6	12.1	15.0	5.7	25.6	3.9	7.1	11.1	11.6	9.4
Race/Ethnicity										
White	25.3	60.8	28.4	77.6	30.6	72.3	13.0	78.3	22.9	71.2
Black	21.7	24.6	22.7	10.5	16.8	14.6	15.5	12.7	20.2	16.6
Hispanic	26.5	9.1	29.2	5.5	20.2	9.1	17.8	4.9	24.6	6.9
Other	27.2	5.5	16.4	6.4	31.3	3.9	14.0	4.1	21.0	5.2
Education										
Less than high school graduate	46.4	5.2	47.4	4.3	53.5	5.0	35.0	0.7	47.0	3.7
High school graduate or GED	31.4	50.9	31.1	56.3	28.9	57.9	19.5	33.6	28.7	48.1
Beyond high school, no 4 year degree	17.0	30.3	22.5	29.3	24.6	27.5	13.8	42.5	17.7	33.2
College graduate or higher	7.9	13.7	9.7	10.2	15.6	9.6	4.0	23.3	7.0	15.0
Age										
17-20	35.1	23.3	35.4	31.0	33.5	30.9	25.4	12.3	33.6	23.0
21-24	27.5	31.4	34.8	29.5	12.7	39.6	19.8	27.6	27.9	30.6
25-30	21.4	25.2	19.6	19.7	18.7	18.1	9.8	25.5	17.2	23.2
31 or older	12.0	20.1	10.2	19.8	10.9	11.3	7.2	34.6	9.6	23.3
Marital/Accompaniment Status										
Not married	32.6	49.5	34.7	58.9	36.0	57.0	22.6	36.4	31.6	49.0
Married, spouse not present at duty station	25.3	9.2	26.0	7.4	31.0	6.0	18.8	3.7	25.0	6.9
Married, spouse present at duty station	14.8	41.3	14.0	33.7	14.2	36.9	7.8	59.9	11.9	44.1
Pay Grade										
E1-E5	29.9	70.5	33.1	74.0	32.3	78.5	18.3	61.7	28.2	69.7
E6-E9	16.9	17.4	12.1	17.5	12.9	13.0	8.1	18.2	12.7	17.3
W1-W4	3.9	2.3	1.0	0.4	5.1	0.6	*	*	3.7	1.0
O1-O3	4.6	7.4	6.6	5.4	8.9	6.0	4.5	12.3	5.2	8.1
O4-O6	4.4	2.4	5.6	2.7	2.6	1.9	2.8	7.7	3.7	3.9
Time on Active Duty										
1 year or less	25.4	16.3	30.2	27.7	28.2	13.1	17.8	7.0	26.9	16.5
>1 to 2 years	33.1	17.7	38.4	12.8	35.7	20.4	23.5	13.1	32.3	15.3
>2 to 3 years	31.3	13.2	38.2	11.0	30.9	16.4	20.5	10.3	30.4	12.1
>3 to 4 years	25.7	7.1	35.1	7.3	35.7	13.0	17.9	8.4	27.1	8.1
>4 to 9 years	21.2	27.7	23.1	22.2	21.1	22.8	10.6	26.2	18.5	25.4
10 years or more	15.4	18.0	10.1	18.9	15.0	14.3	8.2	35.0	11.1	22.7

(continued)

Table 25 (continued)

Socio-Demographic Characteristic	Service/Alcohol Use Problems									
	Army		Navy		Marine Corps		Air Force		Total DoD	
	Adverse Effects or Dependent	Total	Adverse Effects or Dependent	Total	Adverse Effects or Dependent	Total	Adverse Effects or Dependent	Total	Adverse Effects or Dependent	Total
Region										
Americas	20.8	63.7	27.5	88.8	25.9	79.4	12.8	78.3	21.1	75.9
North Pacific	31.1	4.3	29.0	2.7	34.1	12.8	19.9	4.6	28.4	4.7
Other Pacific	21.8	2.2	23.7	6.0	36.4	6.5	14.9	3.4	23.0	4.0
Europe	31.9	29.[illegible]	19.1	2.5	27.5	1.2	15.5	13.7	27.2	15.4
Time at Present Duty Station										
6 months or less	22.5	30.0	26.8	40.7	26.5	23.9	13.9	20.2	22.7	29.6
7 to 12 months	28.1	27.4	26.6	17.5	28.3	28.2	16.6	16.5	25.3	21.8
>1 to 2 years	25.7	25.3	28.0	24.6	29.7	26.0	15.9	28.4	23.6	26.0
>2 to 3 years	22.9	12.2	27.8	12.7	25.1	13.2	11.0	16.9	20.2	13.7
More than 3 years	17.1	5.2	24.5	4.5	26.6	8.7	9.2	17.9	14.5	8.9
Total	24.6	-	27.1	-	27.7	-	13.6	-	22.5	100.0

Note: For each Service, values under the "Total" heading are column percentages showing the distribution across each characteristic within that Service. Values under the "Adverse Effects or Dependent" heading are row percentages showing the proportion of persons with each row's characteristic who also have experienced problems due to alcohol use.

*Not applicable.

Serious Consequences of Drug Use

- During the past 12 months, 10 percent of E1-E5 personnel experienced one or more serious consequences of drug use (Table 26). Prevalence is higher in the Army (13 percent), the Navy (12 percent) and Marine Corps (11 percent) than in the Air Force (4 percent).

- The prevalence of serious consequences (Table 26) of drug use is higher for work impairment (8 percent) than for physical damage (2 percent), social disruption (3 percent) or other consequences (4 percent).

- Loss of productivity associated with drug use among E1-E5 personnel during the past year was 14 percent. High while working (12 percent) is the most frequently mentioned indicator of productivity loss (Table 27).

- The occurrence of serious consequences of drug use for E1-E5's is positively related to the number of drugs used. The percentage who experience one or more consequences increases as the number of drugs used increases.

- Increases in the frequency of use of marijuana by E1-E5's during the past 30 days are accompanied by increasing numbers who experience serious consequences.

Drug Dependence.

- The prevalence of drug dependence among E1-E5 personnel is 2 percent overall. The Army, Navy, and Marine Corps report 2 percent dependence and the Air Force reports 1 percent. Drug dependence was defined as the occurrence of any of the following: use of heroin, other opiates, barbiturates or other sedatives 5 or more times/week; detoxified because of drug use; experienced withdrawal type symptoms (nausea, stomach cramps) after stopping use of drugs.

- Drug dependence among E1-E5 personnel is positively related to the number of serious consequences. The percentage who experience serious consequences increases as the number of drugs used increases.

Table 26. Serious Consequences of Drug Use During the Past 12 Months for E1-E5's

Consequences	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
Work Impairment										
Received UCMJ punishment[b]	3.4	(0.4)	3.6	(0.9)	3.2	(0.8)	1.5	(0.2)	2.9	(0.3)
Lower performance rating[b]	1.8	(0.3)	2.4	(0.4)	3.5	(0.5)	0.8	(0.1)	1.9	(0.2)
Loss of 3 or more working days	7.4	(0.7)	6.2	(0.5)	5.2	(0.9)	1.9	(0.4)	5.5	(0.3)
Total with any work impairment	9.7	(0.9)	9.0	(1.1)	8.0	(1.3)	3.3	(0.4)	7.7	(0.5)
Physical Damage										
Illness kept from duty 1 week or longer	1.4	(0.3)	0.8	(0.1)	0.7	(0.2)	0.2	(0.1)	0.9	(0.1)
Hospitalized for 2 or more days	0.6	(0.2)	0.4	(0.1)	0.7	(0.2)	0.1	(0.1)	0.4	(0.1)
Visited physician 2 or more times	0.7	(0.1)	0.4	(0.2)	0.4	(0.3)	0.1	(**)	0.4	(0.1)
Hurt in accident[b]	1.3	(0.2)	0.8	(0.2)	0.6	(0.4)	0.3	(0.1)	0.9	(0.1)
Had accident causing injury to others or property damage[b]	1.3	(0.3)	0.9	(0.2)	0.6	(0.4)	0.3	(0.1)	0.9	(0.1)
Total with any physical damage	2.8	(0.4)	2.1	(0.2)	1.8	(0.4)	0.5	(0.1)	1.9	(0.2)
Social Disruption										
Spouse left[b]	0.9	(0.1)	0.6	(0.1)	0.4	(0.2)	0.1	(0.1)	0.6	(0.1)
Spouse threatened to leave[b]	1.5	(0.2)	0.8	(0.1)	0.6	(0.3)	0.2	(0.1)	0.9	(0.1)
Arrested for driving under the influence[b]	1.1	(0.2)	0.3	(0.1)	0.4	(0.2)	0.1	(0.1)	0.6	(0.1)
Arrested for nondriving drinking incident[b]	2.2	(0.4)	1.3	(0.2)	1.3	(0.3)	0.6	(0.1)	1.5	(0.2)
Incarcerated[b]	1.6	(0.2)	0.7	(0.2)	0.9	(0.2)	0.2	(0.1)	0.9	(0.1)
Fights	0.0	(**)	0.0	(**)	0.0	(**)	0.0	(**)	0.0	(**)
Total with any social disruption	3.9	(0.4)	2.5	(0.3)	3.1	(0.6)	1.1	(0.1)	2.7	(0.2)
Total with one or more of above consequences[a]	11.2	(1.1)	10.5	(1.0)	10.0	(0.9)	3.7	(0.4)	9.0	(0.5)
Other Consequences										
Did not get promoted[b]	2.8	(0.3)	2.2	(0.6)	2.5	(0.6)	0.8	(0.2)	2.1	(0.2)
Detoxified	1.0	(0.1)	0.7	(0.2)	0.4	(0.2)	0.1	(0.1)	0.6	(0.1)
Hit spouse or children[b]	1.7	(0.2)	1.0	(0.3)	0.8	(0.5)	0.3	(0.1)	1.1	(0.1)
Entered rehabilitation or treatment program[b]	3.4	(0.5)	2.4	(0.6)	1.9	(0.8)	1.5	(0.2)	2.5	(0.3)
Total with any "other consequences"	5.8	(0.6)	4.7	(0.9)	4.4	(0.5)	2.1	(0.2)	4.4	(0.4)
Total with one or more of any consequences listed above	12.5	(1.0)	11.5	(0.9)	10.8	(1.0)	4.3	(0.3)	9.9	(0.5)
Total with one or more of consequences listed included in Burt and Biegel (1980)[c]	9.5	(1.0)	9.3	(1.4)	8.5	(0.3)	4.3	(0.6)	8.1	(0.6)

Note: Tabled values are percentages and represent prevalence estimates with standard errors in parentheses.

[a]All items were included in the Rand Air Force Study (Polich and Orvis, 1979).

[b]Items included in 1980 DoD study (Burt and Biegel, 1980).

[c]All items are from the 1980 study. "I attended a special training or education program because of my use of drugs" was excluded from the 1982 study. Because those who might respond positively to this "special training or education" item are highly likely to have responded positively to other items, the effect on the total scores for the 1980 and 1982 surveys is probably insignificant.

**Informative standard error not available.

Table 27. Loss of Productivity Because of Drug Use During the Past 12 Months for E1-E5's

Productivity Item	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
Lowered Performance	8.3	(0.9)	7.9	(0.5)	5.9	(0.2)	3.1	(0.4)	6.7	(0.4)
Late for Work/Left Work Early	5.2	(0.5)	4.0	(0.5)	3.4	(0.5)	2.0	(0.2)	3.9	(0.2)
Did Not Come to Work	2.3	(0.3)	1.8	(0.5)	1.4	(0.4)	0.4	(0.1)	1.6	(0.2)
High While Working	15.2	(1.4)	12.9	(0.9)	10.3	(0.5)	5.9	(0.3)	11.8	(0.6)
Total With Any Productivity Loss	17.8	(1.5)	15.1	(0.8)	11.3	(0.6)	7.0	(0.4)	13.7	(0.6)

Note: Tabled values are percentages and represent prevalence estimates with standard errors in parentheses.

5. SELECTED COMPARISONS WITH MILITARY AND CIVILIAN POPULATIONS

Understanding the extent of drug and alcohol use in the military requires comparison of the current survey to other studies of military and civilian populations. This chapter makes selected comparisons to two other surveys. The first is the 1980 Worldwide Survey (Burt and Biegel, 1980) on which this study is based. The second is the national civilian household survey conducted by the National Institute on Drug Abuse in 1982 (Miller, Cisin, Gardner-Keaton, Harrell, Wirtz, Abelson, and Fishburne, 1983).

Selected Comparisons with the 1980 Worldwide Survey

Estimates of drug and alcohol use are available for both 1980 and 1982 Worldwide Surveys. However, methodological differences between the surveys (in the questionnaires, the sampling methodology and the field procedures) suggest that caution must be exercised in drawing inferences between the two studies. Despite differences, they are not so serious as to preclude comparisons. The large numbers of personnel surveyed in 1980 and 1982 combined with the similarities of the questionnaire, sample design and procedures offer some measure of robustness to the estimates and suggest that tentative conclusions about levels of use in 1980 and 1982 can be drawn. However, much less can be stated about the reasons for any observed changes. They may be due to a broad range of factors such as shifts in drug enforcement policies, availability, or changes in the level of commitment to use.

Alcohol Use.

- Changes in alcohol use between 1980 and 1982 are apparent by comparing average daily ounces of ethanol consumed during the past 12 months.

- The percentage of total military personnel using .5-1.9 ounces a day increased significantly from 26 to 30 percent (Table 28).

- The percentage of total military personnel using 5 or more ounces a day decreased significantly from 9 percent to 7 percent (Table 28).

- For the Army and the Air Force, the percentage of abstainers decreased significantly (15 to 11 percent, 15 to 13 percent), and the percentage of personnel using .5 to 1.9 ounces increased significantly (25 to 29 percent, 26 to 30 percent). For the Marine Corps the percentage using .5 to 1.9 ounces increased significantly (28 to 31 percent), and the percentage using 5 or more ounces decreased significantly (12 to 6 percent). The Navy showed no significant differences for any of the levels of consumption (Table 28).

- Overall the trend is for an increase in the proportion of more moderate drinkers and a decrease in the proportion of the heaviest drinkers (Table 28).

Table 28. Comparison of Mean Daily Consumption of Ethanol During the Past 12 Months for 1980 and 1982 Worldwide Surveys

Ounces of Ethanol/Survey	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
None										
1980 Survey	15		10		10		15		13	
1982 Survey	11.4	(0.5)	10.3	(1.4)	13.4	(2.1)	12.5	(0.6)	11.6	(0.5)
t_q	-4.15[a]		0.14		1.14		-2.57[a]		-1.74	
>0.0-0.4										
1980 Survey	35		34		31		44		37	
1982 Survey	35.6	(1.1)	32.2	(1.1)	31.9	(1.6)	42.5	(1.5)	36.3	(0.7)
t_q	0.34		-1.06		0.37		-0.64		-0.64	
0.5-1.9										
1980 Survey	25		29		28		26		26	
1982 Survey	28.9	(0.6)	30.0	(0.8)	30.9	(0.2)	30.2	(0.5)	29.7	(0.3)
t_q	4.15[a]		0.82		9.69[a]		5.57[a]		8.09[a]	
2.0-2.4										
1980 Survey	9		12		12		7		10	
1982 Survey	10.2	(0.5)	12.2	(0.6)	11.8	(1.2)	8.2	(0.7)	10.3	(0.3)
t_q	1.54		0.22		-0.11		1.15		0.65	
3.5-4.9										
1980 Survey	6		5		7		4		5	
1982 Survey	5.8	(0.3)	6.8	(0.7)	6.2	(0.6)	3.5	(0.4)	5.5	(0.3)
t_q	-0.41		1.81		-0.85		-0.78		1.10	
5.0 More										
1980 Survey	10		10		12		4		9	
1982 Survey	8.2	(0.8)	8.5	(1.1)	5.8	(1.4)	3.2	(0.4)	6.7	(0.4)
t_q	-1.32		-0.85		-2.35[a]		-1.21		-3.39[a]	

Note: Tabled values for the surveys are percentages and represent prevalence estimates. Standard errors for the 1982 survey are shown in parentheses. 1980 data are taken from Burt and Biegel (1980), Table IV-70. Statistical significance is evaluated by a quasi t statistic, t_q. Details of the computation of this t test are contained in the main report.

[a] $p < .05$

- There were highly significant increases in 1982 of the percentage of personnel who reported becoming drunk without planning to during the past 12 months. The pattern held for Total DoD (20 to 38 percent) and for each of the Services (Table 29).

- There was a significant increase in the percentages who reported staying drunk more than one day at a time (11 to 15 percent for Total DoD). The pattern was in the same direction for all of the Services although only the Army and the Air Force showed significant increases over 1980 (Table 29).

- There was an apparent significant increase from 7 percent to 9 percent in the occurrence of alcohol dependence. A possible item omission in the computation of dependence may have produced slight underestimates of the problem in 1980 (Table 29).

- The percentage experiencing serious consequences due to alcohol use increased significantly (11 to 14 percent for Total DoD). There was a pattern of more consequences for all Services (Table 29), but only the Army showed a significant increase (11 to 15 percent).

- Overall military personnel in 1982 were significantly more likely to have become drunk, to have stayed drunk, or to have experienced one or more consequences of their drinking.

- There was a significant increase in the percentage of personnel who experienced diminished work performance because of alcohol use in 1982. The pattern was consistent for Total DoD (27 to 34 percent) and for each of the Services (Table 30). Pay grades E1-E5's (31 to 40 percent) and 04-06's (12 to 19 percent) both showed significant increases over 1980.

Drug Use

- Overall drug use had declined significantly in 1982. For Total DoD, the percentage using any drug changed from 27 percent in 1980 to 19 percent.

- The decline in drug use is primarily attributable to the decline in use among E1-E5 personnel (38 to 26 percent). In this pay grade group, all Services showed a decreasing pattern of use, although only the Navy and Marine Corps achieved statistically significant reductions (Table 31).

- Although the general pattern of drug use was lower in 1982 than in 1980, E6-E9's in the Army experienced a significant increase in 1982 from 6 percent to 9 percent (Table 31).

- There was a significant decline in marijuana use during the past 30 days for all military personnel from 26 percent to 16 percent. Much of the decrease seems to be accounted for by the significant decrease in use observed among E1-E5 personnel from 37 percent to 22 percent (Table 32).

Table 29. Comparison of Alcohol Use Events, Alcohol Dependence, and Alcohol Use Consequences Among E1-E5's for 1980 and 1982 Worldwide Surveys

Item/Survey	Service				
	Army	Navy	Marine Corps	Air Force	Total DoD
Became Drunk Without Planning To					
1980 Survey	16	25	23	18	20
1982 Survey	35.9 (0.9)	44.8 (1.4)	40.9 (0.6)	33.4 (1.7)	38.0 (0.7)
t_q	15.65[a]	9.95[a]	20.98[a]	6.46[a]	18.13[a]
Drunk More than One Day at a Time					
1980 Survey	10	16	16	6	11
1982 Survey	16.1 (1.2)	17.8 (1.3)	18.5 (0.9)	8.3 (0.8)	14.6 (0.6)
t_q	3.48[a]	0.93	1.85	1.99[a]	4.07[a]
Alcohol Dependence[b]					
1980 Survey	8	9	11	4	7
1982 Survey	10.5 (0.8)	11.6 (1.0)	10.3 (1.8)	4.0 (0.7)	9.0 (0.5)
t_q	2.05[a]	1.81	- .25	0.0	2.71[a]
One or More Consequences of Alcohol Use					
1980 Survey	11	14	17	6	11
1982 Survey	15.2 (1.1)	15.3 (1.5)	17.6 (1.8)	8.7 (1.1)	13.6 (0.6)
t_q	2.52[a]	0.58	0.22	1.72	2.90[a]

Note: Tabled values for the surveys are percentages and represent prevalence estimates. Standard errors for the 1982 survey are shown in parentheses. The 1980 data were taken from Burt and Biegel (1980), Tables II-12, II-13, II-14. Statistical significance is evaluated by a quasi t statistic t_q. Details of the computation of this test are contained in the main report.

[a] $p < .05$

[b] The computation of alcohol dependence may have differed slightly between 1980 and 1982. The 1982 computation followed that of Polich and Orvis (1979) in using five items as indicators of symptoms of blackouts, tremors (shakes), impaired control, and morning drinking. For the 1980 computation, Burt and Biegel (1980, p. 248) indicate that they followed the Polich and Orvis definition, but they only mention four items in their discussion of the dependence measure. The unmentioned item deals with tremors. If the omission occurred, its effect would be a slight underestimate of dependence in 1980.

Table 30. Comparison of Diminished Work Performance Because of Alcohol Use During the Past 12 Months for 1980 and 1982 Worldwide Surveys

Pay Grade/Survey	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
E1-E5										
1980 Survey	29		40		38		24		31	
1982 Survey	38.6	(1.1)	47.4	(2.5)	41.6	(2.4)	33.2	(1.7)	40.1	(0.9)
t_q	5.65[a]		1.95		0.99		3.69[a]		6.70[a]	
E6-E9										
1980 Survey	16		25		25		16		19	
1982 Survey	20.3	(1.7)	25.3	(0.8)	20.8	(2.3)	19.3	(1.7)	21.4	(0.8)
t_q	1.66		0.24		-1.16		1.31		1.97	
W1-W4										
1980 Survey	4		12		*		*		9	
1982 Survey	16.6	(3.6)	19.3	(11.0)	*	(*)	*	(*)	18.5	(3.9)
t_q	2.91[a]		0.48		*		*		1.83	
O1-O3										
1980 Survey	15		29		21		12		17	
1982 Survey	19.9	(3.7)	27.7	(4.3)	23.4	(8.0)	21.5	(2.8)	22.2	(1.9)
t_q	0.88		-0.20		0.20		2.48[a]		1.86	
O4-O6										
1980 Survey	7		14		15		15		12	
1982 Survey	19.3	(2.7)	23.3	(3.3)	31.8	(8.0)	16.9	(1.7)	19.3	(1.4)
t_q	3.53[a]		2.04[a]		1.58		0.74		3.71[a]	
Total										
1980 Survey	24		35		34		20		27	
1982 Survey	33.1	(0.8)	41.7	(1.8)	37.6	(1.2)	28.0	(1.7)	34.4	(0.7)
t_q	7.48[a]		2.47[a]		2.00[a]		3.24[a]		7.04[a]	

Note: Data are percentages who report one or more occurrences due to alcohol of lowered work performance, coming late to work or leaving early, not coming to work, or being drunk or high at work. Tabled values represent prevalence estimates with standard errors in parentheses. The 1980 data are taken from Burt and Biegel (1980), Tables IV-87 - IV-92. Statistical significance is evaluated by a quasi t statistic, t_q. Details of the computation of this t test are contained in the main report.

[a] $p<.05$

* Not applicable.

+ Less than 20 respondents

Table 31. Comparison of Any Nonmedical Drug Use During the Past 30 Days for 1980 and 1982 Worldwide Surveys

Pay Grade/Survey	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
E1-E5										
1980 Survey	41		48		48		21		38	
1982 Survey	34.3	(2.2)	20.9	(3.1)	25.3	(1.5)	18.1	(1.4)	25.6	(1.3)
t_q	-1.81		-5.02[a]		-8.98[a]		-1.28		-5.66[a]	
E6-E9										
1980 Survey	6		6		5		2		5	
1982 Survey	8.5	(0.8)	3.1	(0.7)	3.1	(1.0)	2.2	(0.4)	4.8	(0.4)
t_q	2.23[a]		-2.21[a]		-1.13		0.33		-0.32	
W1-W4										
1980 Survey	5		0		+		*		3	
1982 Survey	4.1	(1.6)	0.0	(**)	+	(+)	*	(*)	3.5	(1.3)
t_q	-0.31		*		*		*		0.26	
O1-O3										
1980 Survey	5		3		5		2		4	
1982 Survey	4.4	(1.1)	2.8	(1.1)	4.7	(1.9)	1.6	(0.4)	2.9	(0.5)
t_q	-0.32		-0.12		-0.10		-0.61		-1.28	
O4-O6										
1980 Survey	0		0		2		1		1	
1982 Survey	2.0	(1.3)	0.1	(0.1)	0.0	(**)	0.7	(0.5)	0.8	(0.4)
t_q	1.54		1.00		*		-0.38		-0.31	
Total										
1980 Survey	29		33		37		14		27	
1982 Survey	26.2	(1.8)	16.2	(2.2)	20.6	(2.0)	11.9	(1.5)	19.0	(1.0)
t_q	-0.95		-4.26[a]		-4.84[a]		-0.87		-4.75[a]	

Note: Tabled values for the surveys are percentages and represent prevalence estimates. Standard errors for the 1982 survey are shown in parentheses. 1980 data are taken from Burt and Biegel (1980), Table III-82. Statistical significance is evaluated by a quasi t statistic, t_q. Details of the computation of this t test are contained in the main report.

[a] $p < .05$.

* Not applicable.

+ Less than 20 respondents.

** Informative standard error not available.

Table 32. Comparison of Marijuana/Hashish Use During the Past 30 Days for 1980 and 1982 Worldwide Surveys

Pay Grade/Survey	Service								Total DoD	
	Army		Navy		Marine Corps		Air Force			
E1-E5										
1980 Survey	40		47		47		20		37	
1982 Survey	31.7	(2.1)	17.5	(2.8)	21.3	(1.2)	15.0	(1.1)	22.5	(1.2)
t_q	-2.33[a]		-5.78[a]		-12.22[a]		-2.74[a]		-6.99[a]	
E6-E9										
1980 Survey	5		6		5		2		4	
1982 Survey	6.6	(0.5)	2.4	(0.6)	2.2	(2.0)	1.3	(0.5)	3.6	(0.3)
t_q	2.25[a]		-2.92[a]		-0.74		-0.80		-0.85	
W1-W4										
1980 Survey	5		0		+		*		3	
1982 Survey	3.7	(1.6)	0.0	(**)	+	(+)	*	(*)	3.1	(1.3)
t_q	-0.44		*		*		*		0.05	
O1-O3										
1980 Survey	5		2		5		2		3	
1982 Survey	3.5	(1.2)	0.8	(0.8)	0.3	(0.3)	0.7	(0.3)	1.6	(0.5)
t_q	-0.69		-0.73		-3.34[a]		-1.97		-1.47	
O4-O6										
1980 Survey	0		0		2		1		1	
1982 Survey	1.7	(1.2)	0.1	(0.1)	0.0	(**)	0.0	(**)	0.4	(0.3)
t_q	1.42		1.00		*		*		-0.99	
Total										
1980 Survey	28		32		36		14		26	
1982 Survey	23.9	(1.7)	13.4	(2.0)	17.1	(2.0)	9.6	(1.1)	16.5	(0.9)
t_q	-1.45		-4.94[a]		-5.34[a]		-2.33[a]		-6.09[a]	

Note: Tabled values for the surveys are percentages and represent prevalence estimates. Standard errors for the 1982 survey are shown in parentheses. 1980 data are taken from Burt and Biegel (1980), Table III-1. Statistical significance is evaluated by a quasi t statistic, t_q. Details of the computation of this test are contained in the main report.

[a] $p < .05$.

* Not applicable.

+ Less than 20 respondents.

** Informative standard error not available.

- In general, changes in marijuana use were similar to the changes observed for use of any drugs. This is explained by the fact that marijuana is the drug used most frequently and accounts to a large extent for the general pattern of overall drug use.

- Significant decreases in marijuana use were observed between 1980 and 1982 for the Navy, Marine Corps, and Air Force, but not the Army, although even here there was a trend toward a reduction (Table 32).

- In the Army, E6-E9's showed a significant increase in marijuana use from 5 to 7 percent (Table 32).

- Comparison of 1980 and 1982 levels of use among E1-E5's for individual drugs showed an overall pattern of reductions for each drug. Significant decreases in use occurred for all the drugs except PCP and heroin (Table 33).

- There was a significant decline in the percentage using more drugs than they had planned from 10 percent to 7 percent (Table 34).

- There was a corresponding reduction in the percentage of personnel reporting that they had been high more than one day at a time from 17 percent to 9 percent (Table 34).

- The percentage indicating drug dependence declined from 4 percent to 2 percent (Table 34).

- There was no significant difference in the percentage who experienced one or more consequences due to drug use for Total DoD. A significant decrease was observed for the Marine Corps, however, from 15 percent to 9 percent (Table 34).

- Reports of diminished work performance due to drug use decreased significantly for Total DoD from 21 to 14 percent. Each of the indicators of diminished performance showed a significant reduction at the Total DoD level and each Service showed a corresponding significant reduction (Table 35).

Comparisons with Civilian Population

Table 36 presents data from the 1982 Worldwide survey and 1982 NIDA survey of the general population. Data were for males aged 18-25 in both surveys, the population most at risk for nonmedical drug use. The civilian sample was standardized on the basis of the joint probability distribution of the military with respect to age, marital status, and education. In the two surveys, comparable data on use in the past 30 days were available for alcohol, marijuana, hallucinogens, cocaine, stimulants, tranquilizers, and heroin.

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Table 33. Comparison of Nonmedical Drug Use During the Past 30 Days Among E1-E5's for 1980 and 1982 Worldwide Surveys

Drug	1980 Survey	1982 Survey	Percentage Change	t_q	Significance Level
Marijuana	37	22.5 (1.2)	14.5	-6.99	.001
PCP	1	0.9 (0.1)	0.1	-.61	NS
LSD/Hallucinogens	5	3.0 (0.3)	2.0	-3.60	.002
Cocaine	7	4.0 (0.4)	3.0	-4.00	.002
Amphetamines/Stimulants	9	6.2 (0.5)	2.8	-3.18	.01
Tranquilizers	3	1.6 (0.2)	1.4	-3.61	.002
Barbiturates/Sedatives	3	1.6 (0.1)	1.4	-7.23	.001
Heroin	1	0.7 (0.1)	0.3	-1.70	NS
Any Drug	38	25.6 (1.3)	12.4	-5.66	.001

Note: Tabled values for the 1980 and 1982 Surveys are percentages and represent prevalence estimates. Standard errors for the 1982 survey appear in parentheses. Statistical significance is evaluated by a quasi t statistic, t_q. Details of the computation of this t test are contained in the main report.

NS = Not significant.

Table 34. Comparison of Drug Use Events, Drug Dependence, and Drug Use Consequences Among E1-E5's for 1980 and 1982 Worldwide Surveys

	Service				
Item/Survey	Army	Navy	Marine Corps	Air Force	Total DoD
Used More Drugs Than Planned					
1980 Survey	9	13	14	6	10
1982 Survey	8.6 (0.8)	8.3 (0.5)	7.4[a] (0.3)	3.5[a] (0.5)	7.1[a] (0.4)
t_q	-0.30	-5.43[a]	-11.84[a]	-2.70[a]	-4.16[a]
High More than One Day at a Time					
1980 Survey	16	22	24	9	17
1982 Survey	11.3[a] (1.1)	10.0[a] (1.0)	9.3[a] (0.5)	4.4[a] (0.3)	9.0[a] (0.5)
t_q	-2.36[a]	-6.36[a]	-14.67[a]	-7.83[a]	-8.48[a]
Drug Dependence					
1980 Survey	5	4	5	1	4
1982 Survey	2.2[a] (0.3)	2.1[a] (0.4)	1.5[a] (0.1)	0.5 (0.2)	1.6[a] (0.2)
t_q	-4.28[a]	-2.54[a]	-14.95[a]	-1.27	-5.58[a]
One or More Consequences of Drug Use					
1980 Survey	11	13	15	5	10
1982 Survey	9.5 (1.0)	9.3 (1.4)	8.5[a] (0.3)	4.3 (0.6)	8.1 (0.6)
t_q	-0.87	-1.58	-11.95[a]	-0.71	-1.89

Note: Tabled values for the surveys are percentages and represent prevalence estimates. Standard errors for the 1982 survey are shown in parentheses. The 1980 data are taken from Burt and Biegel (1980), Tables II-4, II-5, and II-6. Statistical significance is evaluated by a quasi t statistic, t_q. Details of the computation of this t test are contained in the main report.

[a] $p<.05$

Table 35. Comparison of Diminished Work Performance Because of Drug Use During the Past 12 Months Among E1-E5's for 1980 and 1982 Worldwide Surveys

Type of Impairment/Survey	Service				
	Army	Navy	Marine Corps	Air Force	Total DoD
Lowered Peformance					
1980 Survey	12	15	13	3	10
1982 Survey	8.3 (0.9)	7.9 (0.5)	5.9 (0.2)	3.1 (0.4)	6.7 (0.4)
t_q	-2.24[a]	-7.75[a]	-18.11[a]	0.16	-4.65[a]
Late for Work/ Left Work Early					
1980 Survey	8	8	8	2	6
1982 Survey	5.2 (0.5)	4.0 (0.5)	3.4 (0.5)	2.0 (0.2)	3.9 (0.2)
t_q	-2.97[a]	-4.23[a]	-4.53[a]	0.00	5.83[a]
Did Not Come to Work					
1980 Survey	6	4	5	1	4
1982 Survey	2.3 (0.3)	1.8 (0.5)	1.4 (0.4)	0.4 (0.1)	1.6 (0.2)
t_q	5.37[a]	-2.22[a]	-3.74[a]	-2.79[a]	-5.58[a]
High While Working					
1980 Survey	21	26	25	8	19
1982 Survey	15.2 (1.4)	12.9 (0.9)	10.3 (0.5)	5.9 (0.3)	11.8 (0.6)
t_q	-2.32[a]	-8.01[a]	-15.02[a]	-4.09[a]	-6.71[a]
Total With Any Diminution					
1980 Survey	22	28	28	9	21
1982 Survey	17.8 (1.5)	15.1 (0.8)	11.3 (0.6)	7.0 (0.4)	13.7 (0.6)
t_q	-1.62[a]	-9.14[a]	-14.27[a]	-2.97[a]	-6.92[a]

Note: Tabled values for the surveys are percentages and represent prevalence estimates. Standard errors for the 1982 survey are shown in parentheses. The 1980 data are taken from Burt and Biegel (1980), Table III-93. Statistical significance is evaluated by the quasi t statistic, t_q. Details of the computation of this t test are contained in the main report.

[a] $p < .05$

Table 36. Prevalence in 1982 of Nonmedical Alcohol and Drug Use Among Male Enlisted Personnel and Male Civilians Aged 18-25

Drug	Military		Civilians		t_q
Alcohol	85.6	(0.5)	75.7	(3.9)	2.52[a]
Marijuana	25.1	(0.6)	34.7	(4.4)	-2.16[a]
LSD/Hallucinogens	3.8	(0.3)	2.4	(1.0)	1.36
Cocaine	4.6	(0.3)	9.4	(1.9)	-2.48[a]
Stimulants	6.9	(0.3)	4.9	(1.5)	1.30
Tranquilizers	1.7	(0.2)	1.7	(0.9)	0
Heroin	0.7	(0.1)	0.0[b]	-	-

Note: Data are for male enlisted personnel in pay grades E1-E9 (n = 10,868) in the 1982 Worldwide Survey and males 18-25 (n = 468) in the 1982 National Survey on Drug Abuse (Miller et al., 1983). Table values are percentages and represent prevalence estimates. Standard errors are shown in parentheses. Statistical significance is evaluated by a quasi t statistic, t_q. Details of the computation of this test are contained in the main report.

[a]Significant at .05 level.

[b]The were no heroin users in the civilian sampling; therefore, no standard error and corresponding t statistic were computed.

- Alcohol use in the past 30 days is significantly higher in the military population (85.6 percent) than in the comparable civilian population (75.7 percent). Unfortunately, because the civilian survey focused on drug use, more detailed data on the quantity and frequency of alcohol use were not collected. Thus, the meaning of a higher prevalence in the military is not clear.

- Marijuana use in the past 30 days in the military (25.1 percent) is significantly lower than in the civilian population (34.7 percent). In 1980, Burt and Biegel showed that rates in military and civilian populations were similar. Though both rates have dropped since 1980, the reduction found for marijuana was much greater than that found for the civilian population.

- Cocaine use in the past 30 days is significantly lower in the military (4.6 percent) than in the civilian population (9.4 percent). The prevalence of the other types of drugs in the past 30 days is low, and there are no significant differences between the populations. These results are similar to those reported by Burt and Biegel (1980).

6. MULTIVARIATE ANALYSES OF ALCOHOL AND DRUG USE AND THEIR CONSEQUENCES

Analyses presented earlier in this report have examined a variety of aspects of alcohol and drug use behavior and explored the effects of numerous variables associated with them. These analyses provide useful and important information about the effects of alcohol and drug use. However, they are limited by the fact that they have examined the effects of one or two variables (e.g., Service, region, pay grade) but have not controlled for effects of other relevant variables (e.g., demographic variables like age, education, marital status or attitudinal and behavioral variables).

The investigation of the effects on drug and alcohol use of several variables simultaneously is achieved most easily by the use of sophisticated multivariate statistical techniques. One such technique that is applicable to this task is multiple regression analysis. In multiple regression analysis a set of independent variables is examined to determine how well they can jointly account for or explain the variation that occurs in the criterion variable of interest. Collectively the set of variables tested in the analysis is referred to as the regression model. Thus, for example, regression analysis could be used to examine the question of how much drug use behavior can be explained by demographic characteristics of military personnel. The strength of a multiple regression analysis is that each variable is adjusted for the effects of all other variables that appear in the model. Thus it is possible to determine how well the set of variables tested accounts for the variance of the criterion measure and, further, to identify which variables in the set are important in explaining the criterion behavior.

Several exploratory analyses were performed using multiple regression analysis for the 1982 Worldwide Survey. All of these analyses were limited to enlisted personnel (E1-E9) for both theoretical (e.g., officers and enlisted personnel have different motivations for being in the military) and practical reasons (e.g., the highest incidences of drug use and drinking problems occur among enlisted individuals).

The criterion variables to be explained that were examined were: mean number of ounces of ethanol consumed daily; consequences of alcohol use; drug use during the past 30 days; and consequences of drug use. The independent variables used to explain the criterion measures were of two broad types: demographic variables and psychological/behavioral variables. The demographic variables that were included were Service, race, sex, education, marital status, region, pay grade, and age. The psychological/behavioral variables that were examined consisted of a series of indexes (comprised of several items from the questionnaire) along with selected individual items. More specifically the psychological/behavioral indexes included a Problem Behavior Index, Drugs Impair Health/Work Index, Drug Social Support Index, Drug Treatment Climate Index, Alcohol Social Support Index, Alcohol Treatment Climate Index, Drinking Motivation Index, Reasons for Not Drinking Index. The development of these indexes is described in detail in the main report by Bray et al. (1983). Other selected items included church attendance, smoking level, need a drink at work, need an upper at work, ethanol use and drug use patterns.

Table 37. Summary of Regression Models for Enlisted Personnel

Independent Variables	Criterion Variables: Ethanol Consumption (N = 18,284)	Alcohol Use Consequences (N = 16,326)	Drug Use Past 30 Days (N = 18,304)	Drug Use Consequences (N = 5,205)
Demographic Variables				
Service				
Army versus Air Force	.032	-.015	.054**	.077
Navy versus Air Force	.144	-.019	-.033*	.094
Marines versus Air Force	.011	.058	.011	.083
Race				
Hispanic versus White	.265*	.129*	-.010	.169
Black versus White	.139	-.111*	-.014	.175
Other versus White	-.105	.010	-.031	199
Sex (Female versus Male)	-.481**	-.067	.016	.001
Education (High School or beyond versus less than High School or GED)	-.025	-.073	-.036**	-.005
Marital Status (Single or married, spouse not present versus married, spouse present)	.391**	.039	.031**	-.012
Region				
Americas versus Europe	-.455**	-.003	.001	-.144
North Pacific versus Europe	-.261	.070	-.066**	-.008
Other Pacific versus Europe	-.251	-.024	.032	-.092
Pay Grade (E1-E5 versus E6-E9)	.115	.052	.037*	.268
Age (Years)	.004	.006	.004**	-.003
Psychological/Behavioral Variables				
Problem Behavior Index[a]	.420**	.456**	.029**	.239**
Drugs Impair Health/Work Index[a]	-	-	.103**	.081*
Drug Social Support Index[a]	-	-	.040**	.051
Drug Treatment Climate Index[a]	-	-	-.026**	.035
Need an Upper at Work[a]	-	-	.023**	.128**
Drug Use Pattern				
Non Use vs. Marijuana only	-.421**	-.036	-	-
Other Use vs. Marijuana only	.737**	.276**	-	.277**
Alcohol Social Support Index[a]	.136**	.032	.012*	-
Alcohol Treatment Climate Index[a]	.020	-.041*	-.022**	-
Reasons for Not Drinking Index[a]	-.309**	.051**	-	-
Drinking Motivation Index[a]	.453**	.176**	.021**	-
Church Attendance[a]	-.103**	-.007	-.013**	.041
Smoking Level[a]	.267**	.075**	-	.110**
Need a Drink at Work[a]	.297**	.046*	-	-
Ethanol (ounces)	-	.081**	.019**	.052**
R^2 for Complete Model	.238	.290	.273	.131
R^2 for Demographic Variables Only	.057	.036	.089	.020
Addition to R^2 of Psychological/ Behavioral Variables	.181	.254	.184	.111

Note: Tabled values are regression parameters (beta values). Analyses used weighted data. Criterion variables for the four regressions were: Average daily ounces of ethanol consumed during the past 12 months; total number of serious consequences experienced as a result of alcohol use (analysis excluded alcohol abstainers); any drug use (yes, no) during the past 30 days; and total number of serious consequences experienced (based on drug users only). Construction of these measures are described in the main report (Bray et al., 1983).

Values of the regression parameters indicate the change in the criterion variable that is produced by each independent variable after that variable has been adjusted for all other variables appearing in the model. For example, males consume .481 more ounces of ethanol/day than females; males experience .067 more consequences than females from alcohol use; males are .016 more likely to use drugs in the past 30 days than females; and males experience virtually no more consequences (.001) than females from drug use.

[a]Standardized to unit variance.

-Variable not included in regression model.

*p< .01

**p< .001

The regression analyses that were conducted used all of the demographic variables noted above and relevant subsets of the psychological/behavioral variables. For each analysis, a weighted least squares approach was followed in which all variables that were being examined in a particular model were included simultaneously in the model analyses. Thus these analyses did not use a stepwise approach in which statistical criteria are used to select which variables enter the model and the order in which they enter a regression. However, since the demographic variables were listed in the model before the psychological variables, it is possible to examine the explanatory effects (indicated by R^2) of the demographic variables by themselves as well as that of the total set of variables. Further, by subtracting the R^2 of these two, the contribution of the psychological/behavioral to the total variance explained variables can be assessed.

Average Ethanol Consumption

- The regression model of average daily ounces of ethanol for enlisted personnel examined 17 variables (8 demographic, 9 psychological/behavioral) and explained 24 percent (R^2 for complete model) of the variation of the ethanol index (Table 37).

- Overall demographic variables performed rather poorly in explaining ethanol consumption. By themselves, they explained only 6 percent of the variation in ethanol consumption.

- Demographic variables that showed significant differences were the Hispanic/white racial contrast, sex, marital status and the Americas/Euror regional contrast (Table 37). Hispanics consume .265 ounces/day more ethanol than whites. Males consume nearly half an ounce/day (.481) more ethanol than females. Single personnel or those married with their spouses not present consume .391 ounces/day more than those who are married with a spouse present.

- In contrast to demographic variables, psychological/behavioral variables in the model explain most of the variation in ethanol consumption. The explained variance increases by 18 percent over that with the demographic variables alone.

- All but one of the psychological/behavioral variables are highly significant (Table 37). Problem behaviors and drinking motivation are important indicators of ethanol consumption. A change in one standard deviation on either scale is associated with a change of about four-tenths of an ounce (approximately one drink) of daily ethanol consumption (.420 and .453, respectively). Drug Use Patterns also contribute to an understanding of ethanol consumption. Marijuana only users consume approximately four-tenths of an ounce/day more alcohol than nonusers. Any other use of drugs either singly or in combination is accompanied by an increase of nearly three-fourths of an ounce/day (.737) over that consumed by marijuana only users.

Table 38. Effects of Adjusting for Regression Model Variables on Criterion Variables in the Services

Criterion Variable	Service			
	Army	Navy	Marine Corps	Air Force
Average Daily Ounces of Ethanol				
Unadjusted Means	1.97	1.60	1.81	1.18
Adjusted Means	1.73	1.84	1.71	1.70
Number of Alcohol Use Consequences				
Unadjusted Means	.62	.50	.75	.31
Adjusted Means	.57	.56	.64	.58
Probability of 30 Day Drug Use				
Unadjusted Means	.30	.16	.22	.13
Adjusted Means	.25	.16	.21	.20
Number of Drug Use Consequences				
Unadjusted Means	.73	.51	.65	.27
Adjusted Means	.56	.58	.57	.48

Note: Parameters appearing in the regression models are shown in Table 37. Unadjusted means show the values for the Services without controlling for any other variables. All tables in prior chapters of this report that are displayed by Service contain unadjusted values. Statistical tests for each criterion variable on the unadjusted means show a highly significant difference ($p < .001$) among the Services.

Adjusted means show the values for the Services after controlling for all other variables in the regression models. After the adjustment, significant differences occur only for the drug use criterion. The adjusted means do not differ significantly among the Services for ethanol consumption, alcohol use consequences or drug use consequences (see Table 37).

- There were no significant differences among the Services in ethanol consumption after controlling for all other variables in the regression model (Table 37). In contrast, without controlling for any variables, highly significant differences do occur among the Services (Table 38). This suggests that existing Service differences in ethanol consumption can be explained by differences in demographic and psychological/behavioral characteristics.

Alcohol Use Consequences

- The regression model for the number of alcohol use consequences during the past 12 months among enlisted personnel examined 18 variables (8 demographic, 10 psychological/behavioral) and explained 29 percent of the variation (R^2 for complete model) in the number of consequences experienced (Table 37).

- Demographic variables were relatively unimportant in accounting for alcohol consequences, explaining only 4 percent of the variation. Race was the only significant demographic variable. Hispanics experience .129 more consequences than whites, and whites experience .111 more consequences than blacks.

- Psychological/behavioral variables were clearly the important ones in explaining alcohol use consequences. Together they accounted for 25 percent of additional variation beyond that of the demographic variables.

- Among the psychological/behavioral variables, all but two were statistically significant (Table 37). The most salient variables from this set are problem behaviors, drug use patterns and drinking motivation. An increase in one standard deviation in the problem behavior index is associated with an increase of .456 consequences on the average. Drug use that encompasses more than marijuana only use is accompanied by an increase of .276 consequences, and an increase of one standard deviation on the drinking motivation index is expected to produce an increase of .176 consequences.

- No significant Service differences occurred after adjusting for all other parameters in the regression model. This contrasts with notable differences among Services prior to controlling for other variables (Table 38).

Drug Use During the Past 30 Days

- The regression model for 30 day drug use examined 18 variables (8 demographic, 10 psychological/behavioral) and explained 27 percent (R^2 for complete model) of the variation in drug use behavior (Table 37).

- Demographic variables were less important than psychological/behavioral variables in explaining drug use behavior. They accounted for 9 percent of the total variation. Significant differences occurred for Service, education, marital status, region, pay grade,

and age, but even among these, regression parameters were quite small. Probabilities of greater drug use were associated with being in the Army compared to the Air Force, and in the Air Force compared to the Navy. Additionally, there is a significantly increased probability of drug use for those who are less educated, single or married with spouse not present, younger, of E1-E5 pay grade, and serving in Europe compared to the North Pacific.

- Psychological/behavioral variables explained most of the variation of drug use behavior in the regression model, contributing an additional 18 percent of the total 27 percent of explained variance. All of the psychological/behavioral variables were significant. The most important variables were the Drugs Impair Work/Health Index, Drug Social Support Index, and the Problem Behavior Index (Table 37). For example, change of one standard deviation among beliefs that drug use is not harmful to health and work performance is associated with an increase of .10 in the probability of drug use.

- Before adjusting for any other variables, large differences exist among the Services in the level of drug use. After controlling for all other variables in the regression model, some significant differences remain between Services although they are relatively small. Notable among the adjusted means is the finding that the Navy replaces the Air Force as the Service with the lowest probability of drug use. The Air Force actually has the lowest unadjusted level of drug use, but the regression analyses suggest that this would probably not be the case if the demographic and psychological/behavioral variables were roughly comparable among the Services (Table 38).

- Drug use behavior appears to be more a function of psychological (e.g., beliefs and attitudes) and behavioral (e.g., problem behavior) characteristics than of demographic characteristics.

Drug Use Consequences

- The regression model for the number of drug use consequences during the past 12 months among enlisted personnel examined 17 variables (8 demographic, 9 psychological/behavioral) and explained 13 percent of the total variability (Table 37).

- Demographic variables were very weak in explaining consequences of drug use, accounting for only 2 percent of the variance. None of the demographic variables was significant.

- Psychological/behavioral variables explained nearly all of the variation of drug use consequences in the regression model. They accounted for an additional 11 percent of the variation, increasing the total variation accounted for to 13 percent.

- Several of the psychological/behavioral variables are significant, but the problem behavior index and drug use pattern stand out as the most important variables. An increase in the problem behavior index of one standard deviation is associated with an increase of .239 consequences. Similarly, use of drugs besides marijuana only is accompanied by an increase of .277 consequences.

- No significant differences appear among Services in the number of adverse drug use consequences after adjusting for all other variables in the regression model. This contrasts with significant differences among Services prior to adjusting for these variables (Table 38).

- Taken together, all regressions of drug and alcohol use and the consequences of that use are better explained by psychological/behavioral variables than by demographic variables.

- In general there was a lack of significant adjusted differences among Services and among regions. These findings suggest that differences in drug and alcohol use and consequences are partly a function of the differing demographic and psychological/behavioral composition among the Services.

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